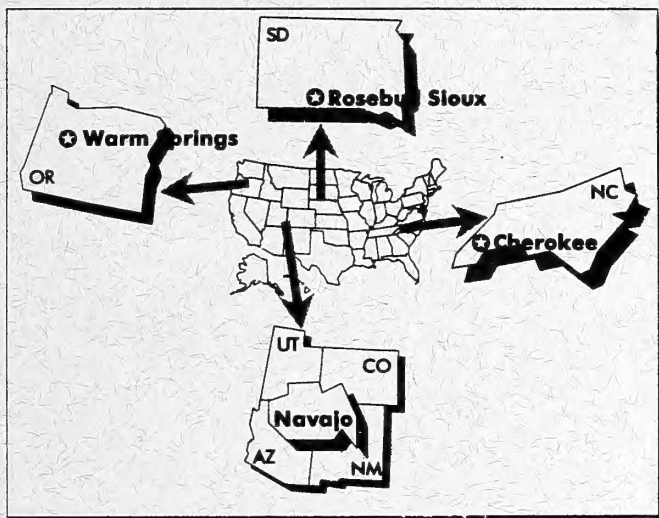


Office of Minority Health
Resource Center
PO Box 37357
Washington, DC 20013-7337

FINAL REPORT

A Case Study of Family Violence in Four Native American Communities



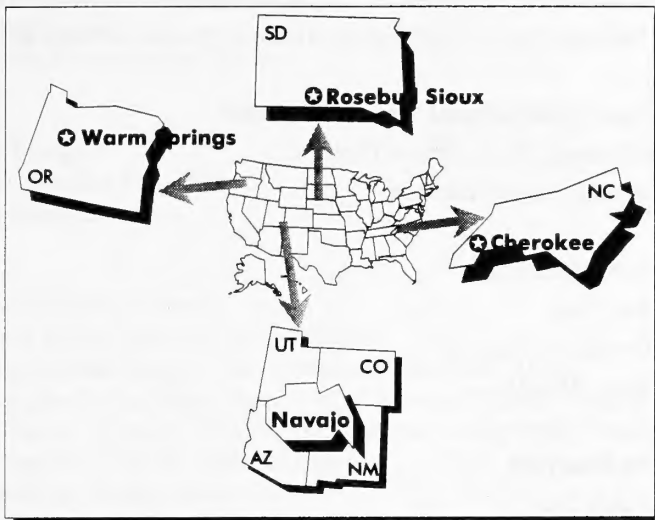
Office of Planning, Evaluation, and Legislation
Indian Health Service
Department of Health and Human Services

MH95D2173

FINAL REPORT

A Case Study of Family Violence in Four Native American Communities

Contract No. 282-90-0035



**Office of Planning, Evaluation, and Legislation
Indian Health Service
Department of Health and Human Services**

Acknowledgements

We gratefully acknowledge the generous assistance of the staff of the Confederated Tribes of Warm Springs, Eastern Band of Cherokee, Navajo Nation, and Rosebud Sioux. In addition, we appreciate the efforts of the staff in the Indian Health Service (IHS) Headquarters, Area Offices, and Service Units, and the Bureau of Indian Affairs (BIA) Area and Agency Offices.

IHS Project Officers

Leo J. Nolan, Director, Division of Program Evaluation and Policy Analysis, OPEL
Lemyra DeBruyn, Ph.D., Chief, Family Violence Prevention Team, IHS Headquarters West

Support Services International, Inc., Contractor

Walter Hillabrant, Ph.D., Project Director
Athena Brown, Project Manager

Research Associates

Judy Earp
Gwendolyn Packard
Mack Rhoades

Systems Analysts

Benny Lin
Maria Perez

Publications/Graphic Design

Caleb Brutus

Research Assistants

Brian Colhoff
Juanita Mendoza
Nicholas Mendoza

This report is made pursuant to Contract No. 282-90-0035. The study was commissioned and supported under the auspices of the IHS Office of Planning, Evaluation, and Legislation (OPEL).

TABLE OF CONTENTS

LIST OF FIGURES AND TABLES	i
EXECUTIVE SUMMARY.	1
I. INTRODUCTION	12
A. Statement of the Problem	12
B. Background	15
1. Definitions of Family Violence	15
C. Goals and Objectives of the Study	16
1. Prior Research	17
D. Strengths/Limitations of Study	17
II. METHOD	19
A. Study Design	19
B. Data Collection Procedures	20
C. Data Analysis	21
III. FINDINGS	21
A. Scope of Family Violence	22
1. Most Severe Form of Family Violence	22
2. Least Severe Form of Family Violence—Husband Abuse	22
3. Variation in Perceived Severity of all Forms of Family Violence	22
B. Components of Family Violence Interventions — Key Study Findings	24
1. Adoption of Family Violence Code	28
2. Establish Victim Support System	29
3. Police Procedures and Training: Victim Assistance Protocol	31
4. Community Education and Involvement	33
5. Coordination of Resources and Programs	35
6. Information Tracking System	37
7. Special Training Initiatives	40
8. Abuser Treatment Protocol	42
C. Summary of Individual Case Studies	42
SITE 1: The Confederated Tribes of Warm Springs	43
SITE 2: Eastern Band of Cherokee	44
SITE 3: Navajo Nation	45
SITE 4: Rosebud Sioux Reservation	46
D. Barriers to Addressing Family Violence	48
1. Denial of the Problem	48
2. Rationalizing Violent Behavior	48
3. Treatment for Perpetrators	48
4. Conflicting Loyalties	48
5. Lack of Positive Role Models	49

IV. RECOMMENDATIONS 49

1. Redirection of Priorities and Resources 49

2. Education/Training 49

3. Community-Based Programs 50

4. Coordination of Programs/Services 50

5. Reporting Systems 50

6. Law Enforcement 51

V. CONCLUSION 51

INDEX 52

ATTACHMENTS

- 1. Confederated Tribes of Warm Springs Case Study Report
- 2. Eastern Band of Cherokee Case Study Report
- 3. Navajo Nation Case Study Report
- 4. Rosebud Sioux Case Study Report
- 5. Annotated Bibliography
- 6. Data Collection Guide
- 7. Types of Secondary Data

LIST OF FIGURES AND TABLES

Figure 1. Severity of Different Forms of Family Violence	23
Figure 2. Average Ratings of Family Violence and General Violence	24
Figure 3. Types of Family Violence, Warm Springs Reservation	43
Figure 4. Types of Family Violence, Cherokee Reservation	44
Figure 5. Types of Family Violence, the Navajo Nation	45
Figure 6. Types of Family Violence, Rosebud Sioux Reservation	47
Table 1. Comparison of Case Study Sites.	19
Table 2. Informants by Case Study Site	20
Table 3. Ratings of the Four Case Study Sites on the Components of Family Violence Prevention Initiatives	26

EXECUTIVE SUMMARY

A CASE STUDY OF FAMILY VIOLENCE IN FOUR NATIVE AMERICAN COMMUNITIES

I. INTRODUCTION

A. Statement of the Problem

Family violence on Indian reservations is devastating for individuals, families, and reservation communities. There are many families in American Indian communities that have experienced violent behaviors, that have coped with violent behaviors positively, and/or wish to learn more about violent behaviors and their prevention. The Indian Health Service (IHS) sponsored this study to produce the information and data needed to guide program planning and development.

In this study, family violence is defined as any of the following: 1) spouse abuse including the beating, battering or sexual abuse of one spouse by the other, 2) child abuse including physical injury, maltreatment of a child under 18 years of age, 3) child neglect, 4) child sexual abuse including persuasion or coercion of a child to engage in sexual activity, and 5) elder abuse including physical or emotional abuse that hinders the life of an elderly person.

B. Goals and Objectives of the Study

This study examined family violence on four American Indian reservations, and identified factors related to family violence. The four reservations studied were The Confederated Tribes of Warm Springs, the Eastern Band of Cherokee, the Navajo Nation, and the Rosebud Sioux.

A case study approach was used to collect primary and secondary data about 1) the nature and prevalence of family violence, and 2) the intervention and prevention measures planned or in place on each reservation. In order to accomplish the study objectives, the following actions were taken:

1. Unstructured interviews were conducted with key informants at each study site including representatives from tribal, Federal, state, and other programs (e.g., health

- care providers, law enforcement, judicial services, social services, education, employment, and private groups, organizations, or shelters) relevant to family violence.
2. Secondary sources of data (e.g., demographic and statistical data, court records, emergency room records, social services, etc.) were collected and reviewed.
 3. A separate report was prepared on the findings of each of the four case study sites.
 4. This final report summarizing the results of the case study was prepared.
 5. A model for developing interventions for preventing or reducing family violence was developed. This model is submitted under separate cover.

C. Strengths/Limitations of Study

The strengths of this study derive from the indepth nature of the investigation.

1. Broad range of informants. Unstructured interviews were conducted with a total of 123 key informants across the four case study sites; indepth interviews were conducted with:

- tribal officials (e.g., tribal chairman, directors of tribal health, social service, judicial services, and other programs)
- program staff working with family violence problems (e.g., tribal police, social service staff, medical staff, shelters and safe house staff)
- officials and staff of state and county programs (e.g., social workers, child protection team members)
- IHS and BIA staff (e.g., mental health program staff, public health nurses, social service staff, members of child protection teams).

2. Wide variation in characteristics of case study sites. The four case study sites (Confederated Tribes of Warm Springs, Eastern Band of Cherokee, Navajo Nation, and Rosebud Sioux) have great variation in history, culture, economy, location, size, and government. This variation makes the study findings robust.

3. Objective orientation of contractor. The informants include a broad range of individuals and groups that have some "stake" in the outcomes of this study. The orientations of different stakeholders were sometimes in apparent harmony and sometimes in apparent conflict. The contractor performing the study had no vested interest in any particular outcome or in any of the case study sites and, therefore, had an objective approach to the study.

The limitations of this study derive from the case study design:

1. Representativeness of the case study data. As with all case studies, the data and the findings reported are qualitative in nature. The statistics reported do not have the reliability associated with large, representative samples in survey research. For this reason, no probability values or confidence intervals were computed for the statistics presented in this study. Likewise, the results of the case study cannot be said to be representative of all American Indian reservations or communities.

2. Pressures to not disclose unfavorable information. In most evaluation research, there are pressures for informants to "look good"—to avoid association with failure or unfavorable circumstances. These pressures are pronounced in studies of family violence which include issues such as the prevalence of child sexual abuse, spouse abuse, and elder abuse. Respondents in each study site acknowledged the difficulty of facing the problem of family violence. These respondents indicated that the pressures against recognizing family violence are so great as to cause American Indian tribes and communities to overlook the problem and, thus, to fail to develop interventions to prevent and reduce family violence. Because of the nature of their jobs, many of the key informants felt that they were exceptions to the tendency to deny family violence in their communities.

II. METHOD

A. Study Design

The design for the study was an embedded multiple case design. It involved multiple sites (four) and multiple units of analysis. The basic unit of analysis was a tribe—the tribes being: 1) Confederated Tribes of Warm Springs in Oregon, 2) Eastern Band of Cherokee in North Carolina, 3) Navajo Nation, and 4) Rosebud Sioux Tribe of South Dakota.

The following criteria were used in selecting the four case study sites: 1) geographic and cultural diversity, 2) willingness of the tribe to participate in the study, 3) availability of secondary data and relevant resources. Once the tribes were identified, a point of contact was established. Through a joint effort, a site visit protocol and itinerary were developed for on-site data collection.

B. Data Collection Procedures

Data were collected through unstructured interviews with key informants from the tribe, IHS Service Units, BIA agencies, and other resources on or near the reservation (e.g., shelters, group homes, children's homes, etc.), and 2) through review of secondary data sources. A Data Collection Guide was developed to assist in the collection of information from informants. A list of secondary data obtained at each study site is presented in the corresponding case study report.

The site visits were conducted over a 3 to 5-day period by four contractor staff (working in teams of two) with extensive experience in conducting interviews and data collection on Indian reservations. Unstructured interviews with key informants were usually 30 minutes to an hour in duration. A total of 123 informants were interviewed in the studies as shown below.

Informants by Case Study Site

SITE	NUMBER OF INFORMANTS
Confederated Tribes of Warm Springs	37
Eastern Band of Cherokee	31
Navajo Nation	33
Rosebud Sioux	22
TOTAL	123

C. Data Analysis

The data for each case study site was analyzed independently. In addition, comparisons among and trends across the four sites were made.

Key informant data. The bulk of the data analysis involved evaluation and synthesis of the information presented by informants in the unstructured interviews. Both consensus and disagreements among informants were noted; more often, however, informants provided information from a different perspective, yet complementary to that provided by other informants.

In addition to observations, judgments, and opinions solicited by the interviewers, the informants were asked to rate the severity of different forms of general violence (e.g., assault, homicide, suicide) and of family violence (e.g., spouse, child, and elder abuse) on their reservation.

Secondary data. Tribes, Federal, state, and county components provided statistical and other data that were compiled, analyzed or reanalyzed. In general, the case studies revealed a paucity of statistics on family violence. Furthermore, the data that exist tended to have a different format, context, and definitions across the four study sites. This general lack of statistics on family violence across the four reservations represent an important study finding. The pertinent secondary data that were collected are reported in the individual case study reports.

III. FINDINGS

This section presents the highlights of the four case studies, individually as well as comparatively, across the four sites. Detailed information on each site is presented in the individual case study reports.

A. Components of Family Violence Interventions — Key Study Findings and Recommendations

The eight components of family violence interventions represent the key findings of the study; each component is discussed, in turn, below.

1. Adoption of Family Violence Code. The code should state the tribe's commitment to protect the victims and, most importantly, to specify penalties and procedures that will ensure the protection of victims from abusers. The code should include:

a. Mandatory Arrest for Probable Cause. Mandatory arrest is a critical feature of the needed shift in policies and procedures. It is simply unrealistic to expect a victim of abuse or neglect to "press charges" against the abuser.

b. Mandatory Treatment or Incarceration for Abuser. Before the alleged abuser is released from detention, there must be a formal hearing that includes testimony of the arresting officers and the introduction of evidence such as a report of a medical examination and testimony of a victim assistance worker who has interviewed the victim. If the outcome of the hearing is that the alleged

abuser is found to have violated the family violence code, he or she should be required to participate in a treatment program (e.g., batterer treatment). Either refusal or failure to participate in the treatment program should, in accordance with the tribal code, result in incarceration of the abuser.

c. Anti-Stalking Law. Such a law makes it a crime to engage in a pattern of spying, following, calling, or otherwise harrassing a victim.

d. Banishment of Repeat Offenders from the Reservation. Victims of family violence should not have to leave the reservation to escape from an abuser; rather an abuser who refuses to stop abusing members of his family should be forced to leave the reservation.

2. Establish Victim Support System. The mission of this support system is the guarantee of reasonable safety and security of victims of family violence. The support system should include:

- Shelters on and off the Reservation
- 24-hour Telephone Hotline
- Emergency Transportation to Shelter or Medical Facility
- Victim Support Groups
- Long Term Housing and Subsistence
- Family Counseling
- Interagency Protocol

3. Police Procedures and Training: Victim Assistance Protocol. The case studies generally revealed that major changes are needed in the training, roles, goals, procedures, and mission of the police with respect to family violence. The victim assistance protocol should include:

- Responsibility for Victim Protection
- Incident Reporting and Documentation
- Testimony and Case Follow-up
- Sensitivity Training
- Utilization of Women Officers

4. Community Education and Involvement. There was a consensus among the informants that without support throughout the tribe or community, family violence prevention initiatives are unlikely to succeed.

5. Coordination of Resources and Programs. Because family violence tends to be a taboo subject, individuals and groups avoid discussion of family violence and fail to directly and explicitly address the problem. The chances of success of an intervention program will be greatly enhanced if every relevant program explicitly focuses on the problem. This focus should include a re-examination of the mission, goals, and objectives of each program with respect to preventing and reducing family violence. Each program should develop protocols to guide program staff in dealing with victims, abusers, and other programs and agencies. Each program should examine its role and responsibilities with respect to each of the eight family violence intervention components discussed in this study.

6. Information Tracking System. Some data relevant to family violence exist in many different information systems; however, the data in these information systems are generally difficult to access, even for the personnel of the agency controlling the system. It is almost impossible for staff of other organizations to access an agency's data. This lack of information sharing can lead to catastrophic consequences for victims of family violence.

a. Uniform Inter-Agency Information System. Such a system would be greatly facilitated if the many relevant agencies had a shared capability such as electronic mail (E-mail); however, it is not necessary to design and implement such a system to support the needed interagency information system. Such a system can be developed using: specially designed paper forms, faxes, telephones, and explicit protocols. A core set of data such as the name, addresses, and telephone numbers of the victim(s) and alleged abuser(s), date of the incident(s), description of the injuries, and the names of agency staff assigned to the case will greatly facilitate implementing family violence initiatives.

b. Assign Responsibility for Maintenance. For the information tracking system to work, some agency should assume responsibility for the maintenance of the data. Given their critical role in preventing family violence (the police officer is often the first person on the scene), the police are a good candidate for this responsibility.

c. Regular Reporting Requirements by Agency. Reporting requirements become meaningful once each relevant agency establishes goals and objectives regarding the prevention and reduction of family violence, and has developed corresponding protocols.

d. Resource List. The availability of resources should be published periodically, and lists of resources should be maintained and updated by all relevant agencies.

7. Special Training Initiatives. The staff of most agencies do not know how to deal effectively with either victims or abusers. The need for training in the area of family violence in many ways parallels the need for training in the area of alcoholism and substance abuse. The training needs of three groups were especially clear in the case studies: the police, IHS medical staff, and allies.

a. Police Training. The actions of untrained police can easily and greatly exacerbate the problem. As the first authority often to respond to an incident of family violence, the police need special training in conjunction with a new protocol for dealing with family violence.

b. Medical Staff (IHS or Tribal). While medical staff often do a good job of treating the injuries of a victim of family violence, they often do a poor job in 1) identifying family violence as a cause of injuries, 2) making the appropriate referrals for victims, 3) providing the appropriate follow-up care, 4) obtaining the type of evidence needed by courts in the prosecution of abusers, and 5) in providing the expert testimony needed by the court. Medical staff need training by experienced experts in all these areas.

The medical staff training should incorporate the recognition, crisis intervention, and referral requirements of the Joint Commission for Accreditation of Health Organizations (JCAHO) as well as the Diagnostic and Treatment Guidelines on Domestic Violence developed by the American Medical Association.

Each Service Unit should have a physician trained in conducting special examinations needed for victims of rape and child sexual abuse. In addition, medical staff should receive special training on providing emotional support designed to minimize the psychological trauma associated with such assaults.

The IHS needs to work with the police and an interagency family violence prevention task force to develop a core data set and a reporting system so that issues of confidentiality do not prevent the flow of information needed to protect the victim(s) and to prosecute the persons who commit violence against the members of their family.

8. Abuser Treatment Protocol. Surprisingly, abusers often receive little or no treatment. Generally, abusers deny committing family violence, police often fail to arrest the abuser and, if arrested, the courts often fail to successfully prosecute the abuser. Even if arrested, convicted, and sentenced to participate in therapy, abusers often terminate treatment without sanction or any follow-up by the authorities.

IV. RECOMMENDATIONS

Based on the study results, six recommendations are proposed.

1. Redirection of Priorities and Resources. In the context of the rationed health care provided by the IHS, most studies seem to conclude that additional resources are needed to achieve the desired end. This study is no exception—it is clear that additional resources are needed to enhance efforts to prevent family violence. As important as more resources is the need for a recognition of the scope of the problem and of the damage created by family violence. All parties involved, the tribes, IHS, BIA, states, and counties must focus on the problem, and make the prevention of family violence a priority.

2. Education/Training. In-Service Training. Special training for "front-line" agencies and programs (e.g., police officers, IHS, medical staff, judicial services, social services, mental health, counseling, etc.) is needed. This should include interdisciplinary training, and focus on the roles and responsibilities of all agencies and parties involved. The need for cooperation among all agencies and personnel should be stressed. Specialized training for physicians is needed in conducting medical examinations of abuse victims, as well as legal protocol in testifying as an expert witness in abuse cases.

School-Based Programs. Early intervention programs designed for the K-12 school system should be implemented. The program should focus on issues related to family violence (e.g., identification, behaviors, prevention, and resources for dealing with the problem).

3. Community-Based Programs. Alcohol and Substance Abuse Treatment Programs. Programs focusing on treatment for alcohol and substance abuse should include, as a key component, initiatives to prevent family violence. Alcohol was cited as a factor in cases of family violence in each study site.

Parenting Programs. Parenting skills are needed by teen parents, as well as by older parents. Parenting programs can be offered in the schools as well as through other supporting organizations and shelters. The programs can offer support groups, provide a valuable referral service to other resources, and address other forms of family violence in addition to child abuse and neglect.

Family Services. Often programs focus treatment efforts toward one family member in a specific age group. Working within the framework, the program only treats this one individual who

subsequently returns or is returned (in case of a minor) to a dysfunctional environment. By working with the family, dynamics within the family can be altered and the cycles of violent behavior can be broken. Follow-up procedures are a critical part of this process.

4. Coordination of Programs/Services. Reservations often have a diverse mix of tribal, Federal, state, and county programs, each with their own guidelines, procedures, protocols, and jurisdiction. Multiple and conflicting protocols and procedures cause confusion for victims of family violence. Often this confusion will result in the victims not seeking or obtaining the needed help. In addition, victims often become second priority, while the conflicts involving jurisdiction and responsibility are resolved.

There is a need to develop 1) an agreement on the division of labor, roles, and responsibility, 2) a coordination plan that is reflected in a reporting system, and 3) reporting and evaluation procedures.

5. Reporting Systems. The various agencies (tribal, Federal, state, and county) with programs addressing family violence each maintain some level of reporting. Often these systems are agency-division-specific, and do not include a tracking system for follow-up activities. There is a need for an accurate reporting system that integrates the various records maintained by each agency or program.

Reporting procedures should be comprehensive and clearly presented in written form to all employees who are likely to encounter family violence. Often the procedures are vaguely understood, or understood, but not written. Staff should be familiar with issues of confidentiality, maintaining patient records, and reporting.

6. Law Enforcement. In-service training is needed for law enforcement staff. Across all study sites, informants reported that law enforcement was the "weak link" in the network of agencies addressing family violence. Appropriate modification of the tribal code, development of family violence prevention procedures, and in-service training for the police should enable police officers to assume active leadership in the protection of victims.

V. CONCLUSION

Every day on some reservation, a batterer known to the community continues to commit acts of violence without being arrested or even detained and questioned. It is as if the abusers were invisible, as if battering a family member were an activity acceptable to the community.

To paraphrase one of the informants: A growing number of voices are saying that family violence cannot be allowed to continue. These voices demand that every person of decency join the chorus, and work to eliminate family violence from our communities. Tribal communities must be willing to undergo self-examination, examining which behaviors perpetrate the violence against women and children. This social change process is critical to the survival of tribal cultures throughout Indian country.

FINAL REPORT

A CASE STUDY OF FAMILY VIOLENCE IN FOUR NATIVE AMERICAN COMMUNITIES

I. INTRODUCTION

A. Statement of the Problem

Family violence on Indian reservations is devastating for individuals, families, and reservation communities. It has a lasting and detrimental effects on the individuals who directly experience the abuse, on the nuclear family, the extended family, and members of the Indian community. There are many families in American Indian communities that have experienced violent behaviors, that have coped with violent behaviors positively, and/or wish to learn more about violent behaviors and their prevention.

Elected officials or "the man in the street" seldom acknowledge or understand the nature and scope of family violence in many American Indian communities. In this study family violence is defined as any of the following: 1) spouse abuse including the beating, battering or sexual abuse of one spouse by the other, 2) child abuse including physical injury or maltreatment of a child under 18 years of age, 3) child neglect, 4) child sexual abuse including persuasion or coercion of a child to engage in sexual activity, and 5) elder abuse including physical or emotional abuse that hinders the life of an elderly person (see page 15 for a more detailed discussion of family violence).

The Indian Health Service (IHS) is aware of the problem of family violence in American Indian communities, as well as the need for strengthening families and communities. To date, there has been little study or analysis of family violence in American Indian communities. This case study was commissioned to increase information about the scope and nature of family violence on four disparate reservation communities, and to develop a model that can be used by tribes and communities to develop interventions designed to prevent and reduce family violence.

During the early part of the twentieth century, many American Indian children were forcibly removed from their homes on the reservation and sent away to boarding schools operated by the Bureau of Indian Affairs (BIA) or by various Christian denominations. These boarding schools functioned as an assimilation tool for the dominant society to enforce their values, teaching the Indian student the ways of a different society. Many young children spent years in these institutional settings, beginning as early as age 5. At the boarding schools, Indian children often received severe corporal punishment for a variety of misdemeanors that included speaking their language, wearing clothes, jewelry or other adornments traditional to their tribe. In general, the boarding schools had the explicit objective of stamping out all aspects of the child's tribal culture. The goal was to create a "white person" beneath the child's brown skin. Among the many devastating effects of the boarding schools was the intergenerational impact. For example, removal from their families at such a young age prevented the children from learning parenting skills from their parents and grandparents. In addition, they missed the experience of a loving and supportive extended family. This resulted in a generation of "unparented parents."

The boarding school was not the only instrument for eradicating the cultures of tribes. The Federal Government, through the War Department, then responsible for administering Indian policy, opposed almost every aspect of tribal culture. This opposition was enforced by military occupation of Indian lands. This systematic attempt to destroy the culture of American Indians along with the forced separation of children from their families is the context which differentiates family violence on Indian reservations and communities from that of most other Americans. Traditional values were eroded as the mainstream society values were imposed on the tribes. This created a dualistic cultural identity where the pressures of assimilation and the strength of the traditional values were pitted against each other.

Review of available data confirms the significance and prevalence of the problem of violence among American Indians. For example, the 1992 IHS Chartbook¹ reveals that:

Homicide is the fourth leading cause of death of Indians 1-14 years old and for 25-44 years old. It is the third leading cause of death for 15-24 years old. The homicide rate for Indians is 71 percent greater than that of all races in the U.S.

The suicide rate among Indians is similar to that of homicide, and is the sixth leading cause of death. This rate is not as high for children up to age 14, and for adults 25-44, but it is

Louis W. Sullivan, M.D., Mason, M.D., Dr. P.H., James O., Rhoades, M.D., Everett R., Reyes, Luana, L., Simermeyer, Edward J., and D'Angelo, Anthony J. *Trends in Indian Health--1993*. Indian Health Service, Rockville, MD, 1993.

higher for 15-24 years old. The suicide rate for Indians is 54 percent greater than that of the rest of the U.S.

The situation for assaults and rape is much the same. It is widely believed that both rape and child sexual abuse are as prevalent in American Indian as in other communities in the United States.

Reliable prevalence data on family violence on reservations is generally lacking; however, it is known that gender and age are critical aspects of family violence. Most of the perpetrators are men, and most of the victims are women and children; nevertheless, family violence knows no class, income, age, race, ethnicity, or education bounds. Family violence occurs among the wealthy and the poor, among the employed and the unemployed; family violence is perpetrated by people with advanced degrees and people with little formal education. Family violence occurs among Indian tribes and communities throughout the United States.

Increased awareness of family violence has prompted the formulation and passage of legislation aimed at putting in place a more effective system of reporting, identifying, and remedying the problem. The *Indian Child Protection and Family Violence Prevention Act of 1990* emanated from a Congressional review of the problem of child abuse on Indian reservations.² The findings from this review revealed that:

- Incidents of abuse of children on Indian reservations are grossly underreported;
- Underreporting is often a result of the lack of mandatory Federal reporting law, and a lack of the resources needed to develop a sophisticated tracking and reporting system;
- Multiple incidents of sexual abuse of children on Indian reservations have been perpetrated by community members and by persons employed or funded by the Federal Government;
- Federal investigations of the background of Federal employees who care for, or teach, Indian children are often deficient;
- Funds spent by the Federal government on Indian reservations or otherwise spent for the benefit of Indians who are victims of child abuse or family violence are inadequate to meet the growing needs for mental health treatment and counseling for victims of child abuse or family violence and their families; and
- There is no resource that is more vital to the continued existence and integrity of Indian tribes than their children and families and the United States has a direct interest, as

²Public Law 101-630, The Indian Child Protection and Family Violence Prevention Act, Section 402(a), November 28, 1990.

trustee, in protecting Indian children who are members of, or are eligible for membership in, an Indian tribe.

B. Background

The lifestyle of the American Indian in reservation communities is different from the non-reservation communities. Also, the disparity between the non-Indian reservation border towns and the Indian reservation is very real and visible. The living conditions on reservations are often extremely harsh due to economic conditions and other factors including isolation, lack of educational opportunities, racism, and an unskilled labor force. These conditions provide the context in which family violence in reservation communities must be understood.

1. Definitions of Family Violence:

Family Violence is defined as the aspects of violence that occur among members of one family group. In this study, the concept of the "extended family" is used. The extended family is an extension of the nuclear family (parents and their children), but in the context of many tribes, the distinction between nuclear and extended family is not sharply defined. Abuse often occurs within extended families as well, e.g., between siblings and cousins.

Abuse is that aspect of family violence that occurs with the acts of physical, sexual, verbal, social or emotional abuse by one person to another.

Child Abuse is the physical, mental, or emotional injury, sexual abuse or exploitation, negligent treatment or maltreatment of a child under the age of 18.

Child Sexual Abuse is the use, persuasion or coercion of a child to engage in any sexually explicit conduct (or any simulation of such conduct). Child sexual abuse includes any depiction of such conduct, rape, molestation, prostitution or incest with children.

Spousal Abuse is a behavior that uses physical, emotional, and sexual forms as a tool to perpetuate violence against the partner. Spousal abuse includes abuse of the husband by the wife (husband abuse) and, the far more common abuse of the wife by the husband (wife abuse).

Elder Abuse is a much like spousal abuse, and can take many forms. The working definition includes any elderly person who has been the recipient of physical, emotional, and social abuse that hinders or influences the way that person lives. This can include passive neglect, material and financial exploitation, and active maltreatment.

This study was commissioned through the IHS Office of Planning, Evaluation, and Legislation (OPEL).

C. Goals and Objectives of the Study

This study examined family violence on four American Indian reservations, and identified factors related to family violence. The four reservations studied were The Confederated Tribes of Warm Springs, the Eastern Band of Cherokee, the Navajo Nation, and the Rosebud Sioux.

A case study approach was used to collect primary and secondary data about 1) the nature and prevalence of family violence, and 2) the intervention and prevention measures planned or in place in each reservation. As part of this study, a culturally-relevant, community-based prevention model was developed for use by Indian tribes and communities.

In order to accomplish the study objectives, the following actions were taken:

1. Unstructured interviews were conducted with key informants at each study site including representatives from tribal, Federal, state, and other programs (e.g., health care providers, law enforcement, judicial services, social services, education, employment, and private groups, organizations, or shelters) relevant to family violence.
2. Secondary sources of data (e.g., demographic and statistical data, court records, emergency room records, social services, etc.) were collected and reviewed.
3. A separate report was prepared on the findings of each of the four case study sites (see Attachments 1-4).
4. This final report summarizing the results of the case study was prepared.
5. A model for developing interventions to prevent and combat family violence was developed. This model is submitted under separate cover.

1. Prior Research

A literature search revealed there is a large array of data available on violence in general, but there is very little data on family violence in American Indian communities. (Attachment 5 contains an annotated bibliography of the literature reviewed).

In recent years, family violence in the United States has been the focus of considerable attention. L. Klein and C. H. Chandler of the Emory School of Medicine stated that "law enforcement officials, support groups, safe houses, and local coalitions to combat the domestic violence are becoming more and more visible."³ In addition, health professionals are becoming more aware of procedures and protocols for medical examinations of victims; physicians and emergency medical personnel often establish the first contact with victims.

Comprehensive national studies on family violence have been conducted; however, few studies have addressed family violence on Indian reservations. A survey was conducted in 1985 entitled "The National Family Violence Resurvey."⁴ One of the few studies, conducted in 1992, examined the etiology of violence in American Indian communities.⁵ Findings from the study include "social disorganization and economic deprivation are important contributors to high levels of lethal violence directed toward others," and "Indians exist in an environment in which they are negatively stereotyped and devalued as individuals." Another finding is "that alcohol and drug use have a direct effect on both internal and external forms of violence."

D. Strengths/Limitations of Study

The strengths of this study derive from the indepth nature of the investigation.

1. Broad range of informants. Unstructured interviews were conducted with a total of 123 key informants across the four case study sites; indepth interviews were conducted with:

- tribal officials (e.g., tribal chairman, tribal council members, tribal health directors, social service, tribal judges, and other programs)

³Klein L. and Chandler C.H. "Domestic Violence: one outlook," *British Journal of Obstetrics and Gynaecology*, December 1989

⁴Straus, M.A. and Gelles, R.J. (Eds.). *Physical Violence in American Families*, New Brunswick, NJ: Transaction Publishers, 1990

⁵Bachman Ronet. *Death and Violence on the Reservation: Homicide, Family Violence, and Suicide in American Indian Populations* New York: Auburn House, 1992.

- program staff working with family violence problems (e.g., tribal police, social service staff, nurses, shelters, safe house staff)
- officials and staff of state and county programs (e.g., social workers, child protection team members)
- IHS and BIA staff (e.g., mental health program staff, public health nurses, social service staff, members of child protection teams).

2. Wide variation in characteristics of case study sites. The four case study sites (Confederated Tribes of Warm Springs, Eastern Band of Cherokee, Navajo Nation, and Rosebud Sioux) have great variation in history, culture, economy, location, size, and government. This variation makes robust study findings of common problems, dynamics, and solutions.

3. Objective orientation of contractor. The informants include a broad range of individuals and groups that have some "stake" in the outcomes of this study. The orientations of different stakeholders were sometimes in apparent harmony and sometimes in apparent conflict. The contractor performing the study had no vested interest in any particular outcome or in any of the case study sites and, therefore, had an objective approach to the study.

The limitations of this study derive from the case study design:

1. Representativeness of the case study data. As with all case studies, the data and the findings reported are qualitative in nature. The statistics reported do not have the reliability associated with large, representative samples in survey research. For this reason, no probability values or confidence intervals were computed for the statistics presented in this study. Likewise, the results of the case study cannot be said to be representative of all American Indian reservations or communities.

2. Pressures to not disclose unfavorable information. In most evaluation research there are pressures for informants to "look good"—to avoid association with failure or unfavorable circumstances. These pressures are pronounced in studies of family violence which include issues such as the prevalence of child sexual abuse, spouse abuse, and elder abuse. Respondents in each study site acknowledged the difficulty of facing the problem of family violence. These respondents indicated that the pressures against recognizing family violence are so great as to cause Indian tribes and communities to overlook the problem and, thus, to fail to develop interventions to prevent and reduce family violence. Because of the nature of their jobs, many of the key informants felt that they were exceptions to the tendency to deny family violence in their communities.

II. METHOD

A. Study Design

The design for the study was an embedded multiple case design. It involved multiple sites (four) and multiple units of analysis. The basic unit of analysis was a tribe—the tribes being: 1) Confederated Tribes of Warm Springs in Oregon, 2) Eastern Band of Cherokee in North Carolina, 3) Navajo Nation, and 4) Rosebud Sioux Tribe of South Dakota.

The following criteria were used in selecting the four case study sites:

- Geographic and cultural diversity
- Willingness of the tribe to participate in the study
- Availability of secondary data and relevant resources.

Once the tribes were identified, a point of contact was established. Through a joint effort, a site visit protocol and itinerary were developed for on-site data collection.⁶

Table 1 provides data on the diversity of the four reservations in the study.

Table 1. Comparison of Case Study Sites

	Eastern Band of Cherokee	Confederated Tribes of Warm Springs	Navajo Nation	Rosebud Sioux
Total Membership	10,320	3,384	20,000	14,772
Reservation Land Area (in 1000 acres)	57	600	17,000	528
Reservation Population	6,800	2,875	151,105	13,050
Number of Reported Cases of Child Abuse or Neglect (in 1 year)	1	215	N/A	N/A
Number of Reported Cases of Child Sexual Abuse	9	59	N/A	N/A

⁶Initially, the design for conducting this study specified the collection of primary data from at least three generations within a sample of families (children, parents, and grandparents) at four different sites. Review of the study design by the Office of Management and Budget (OMB) revealed that a major increase of the sample size would be required. The costs associated with increasing the sample size exceeded the resources available for this study. Therefore, with approval of the IHS Project Officer and the Contracting Officer, the study was redesigned from a sample survey to a case study.

B. Data Collection Procedures

The purpose of the site visits was to collect primary and secondary data concerning the nature of family violence on the reservation, and to identify intervention and prevention measures in place or contemplated. Data were collected through unstructured interviews with key informants from the tribe, IHS Service Units, BIA agencies, and other resources on or near the reservation (e.g., shelters, group homes, children's homes, etc.), and 2) through review of secondary data sources. A Data Collection Guide was developed to assist in the collection of information from informants (see Attachment 6). Attachment 7 is a list of the types of secondary data solicited. A list of secondary data obtained at each study site is presented in the corresponding case study report (Attachments 1-4).

The site visits were conducted over a 3 to 5-day period by four contractor staff (working in teams of two) with extensive experience in conducting interviews and data collection on Indian reservations.

Prior to the site visit, a Data Collection Guide and a list of the types of secondary data needed for the study were forwarded to the point of contact (generally the director of the Tribal Health Program). Unstructured interviews with key informants were usually 30 minutes to an hour in duration. A total of 123 informants were interviewed in the studies as shown in Table 2. The point of contact in conjunction with tribal leaders and representatives, compiled a list of key informants, and helped to develop the interview schedule.

Table 2. Informants by Case Study Site

SITE	NUMBER OF INFORMANTS
Confederated Tribes of Warm Springs	37
Eastern Band of Cherokee	31
Navajo Nation	33
Rosebud Sioux	22
TOTAL	123

The specific persons interviewed and their job titles are given in the individual case study reports.

C. Data Analysis

The data for each case study site were analyzed independently. In addition, comparisons among and trends across the four sites were made.

Key informant data. The bulk of the data analysis involved evaluation and synthesis of the information presented by informants in the unstructured interviews. Both consensus and disagreements among informants were noted; more often, however, informants provided information from a different perspective yet complementary to that provided by other informants.

In addition to observations, judgments, and opinions solicited by the interviewers, the informants were asked to rate the severity of different forms of general violence (e.g., assault, homicide, suicide) and of family violence (e.g., spouse, child, and elder abuse) on their reservation (see Attachment 6). These ratings were tabulated and descriptive statistics (e.g., percentages and means) were computed for each study site. While these statistics are useful in describing general trends and situations, the reader should keep in mind that the number of observations is too small and the method of sampling is not appropriate to use the statistics as reliable estimates of population parameters.

Secondary data. Tribes, Federal, state, and county components provided statistical and other data that were compiled, analyzed or reanalyzed. In general, the case studies revealed a paucity of statistics on family violence. Furthermore, the data that exist tended to have a different format, context, and definitions across the four study sites. This general lack of statistics on family violence across the four reservations represent an important study finding. The pertinent secondary data that were collected are reported in the individual case study reports.

III. FINDINGS

This section presents the highlights of the four case studies, individually as well as comparatively, across the four sites. Detailed information on each site is presented in the individual case study reports (Attachments 1-4). Within this framework, the data are presented in four general categories: nature of family violence, existing programs/services, difficulties in dealing with family violence, and recommendations.

A. Scope of Family Violence

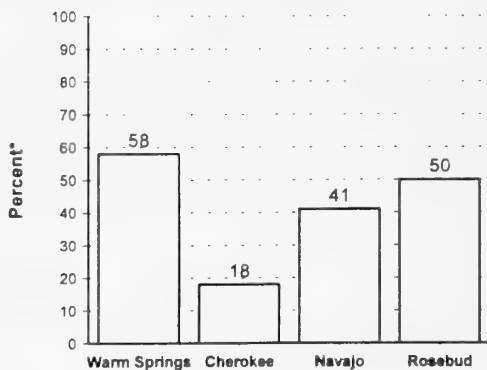
The informants at each case study site were asked to rate the magnitude of various aspects of family violence. In addition, as a baseline for comparison purposes, the informants were asked to rate the severity of various aspects of violence in general. Figure 1 illustrates the judgments of the severity of five types of family violence: wife abuse, child abuse, husband abuse, elder abuse, and child sexual abuse. Inspection of Figure 1 shows areas of both similarity and discrepancy.

1. Most Severe Form of Family Violence. Across the four case study sites, there was no consensus as to which type of family violence represents the biggest problem. Wife abuse was cited by the largest proportion of informants at Navajo, and was tied with child sexual abuse for Warm Springs. Child sexual abuse was the type of family violence most cited at Cherokee. Child abuse was most cited at Rosebud. These data suggest that the perceived severity of specific types of family violence varies across the four reservations.

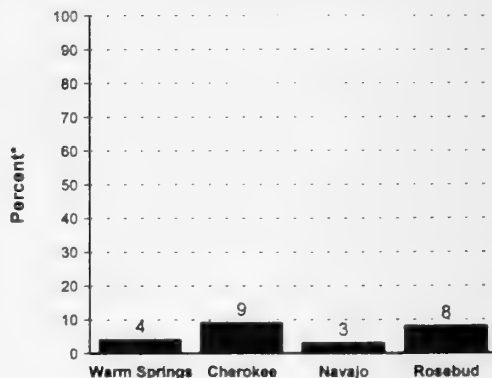
2. Least Severe Form of Family Violence—Husband Abuse. The percentage of informants identifying husband abuse to be a big problem ranged from a low of 3 percent at Warm Springs to a high of 9 percent at Cherokee. At each site, husband abuse was not judged to be a big problem by the majority of informants.

3. Variation in Perceived Severity of all Forms of Family Violence. Informants from Warm Springs and Rosebud tended to judge family violence to be a bigger problem than informants at Cherokee and Navajo. For example, 50 percent or more of the informants at both Warm Springs and Rosebud judged wife abuse, child abuse, and child sexual abuse to be big problems. In contrast, less than 50 percent of the informants at Cherokee (highest was 30 percent) or Navajo (highest was 41 percent) judged any type of family violence to be a big problem on the reservation.

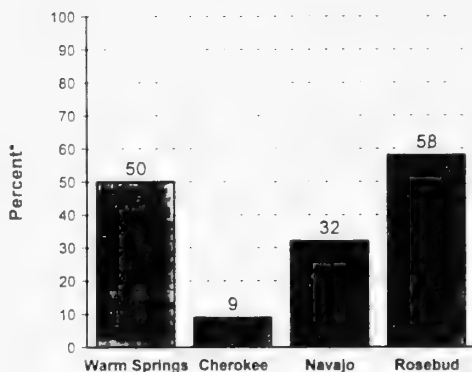
Wife Abuse



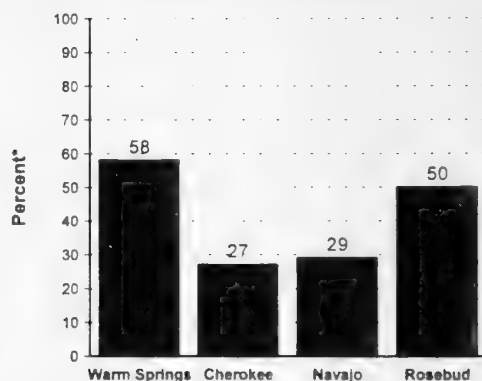
Husband Abuse



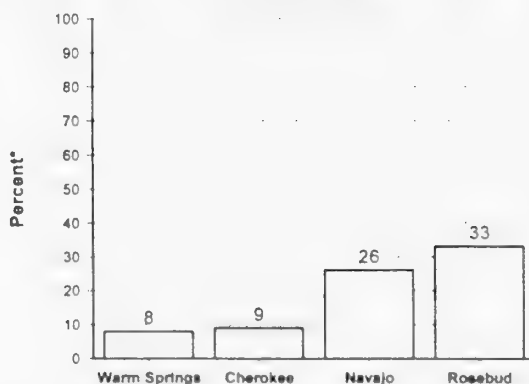
Child Abuse



Child Sexual Abuse



Elder Abuse



*Percent of informants judging each family violence category to be a "Big Problem"

Figure 1. Severity of Different Forms of Family Violence

In order to provide a benchmark to evaluate informants' judgments about the severity of family violence on their reservation, the informants were asked to judge the severity of violence in general and specific types of violence (e.g., homicide, suicide, assault) on the reservation. Figure 2 shows that, on the average, family violence was rated to be an equal or bigger problem than general violence at each study site.

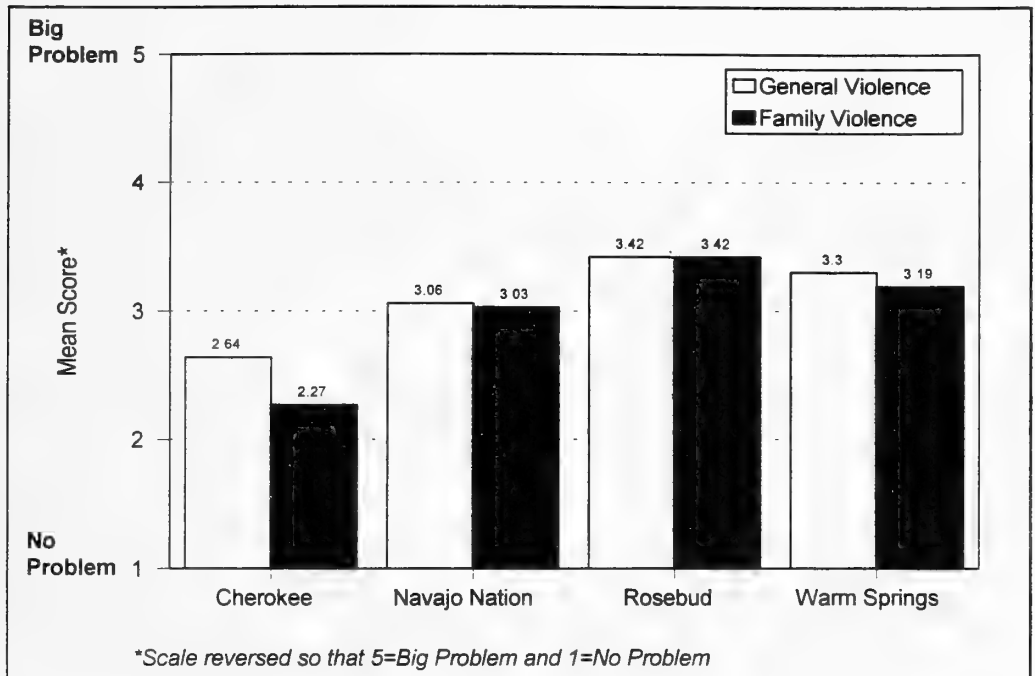


Figure 2. Average Ratings of Family Violence and General Violence

Figure 2 also shows, from another perspective, that informants at Rosebud and Warm Springs judge both family violence and violence in general to be bigger problems on their reservations than do informants at the Cherokee and Navajo reservations.

B. Components of Family Violence Interventions — Key Study Findings

Based on qualitative analysis of the data collected in the four case study sites, a model of family violence interventions was developed. This model has eight basic components and numerous

subcomponents (see Table 3). Once the model was developed, each of the case study sites was rated on the components and subcomponents. The categories used in rating the tribes were:

- DK** = Don't Know or Information Unavailable
- M** = Model Program Component
- P** = Program Component Present
- A** = Program Component Absent
- D** = Program Component Developing

It is important for the reader to note that a rating of DK does not indicate that the component in question does not exist. The model was developed based on the analysis of the case study data, and the ratings were made after the site visits were completed. If the model is useful, it can be adapted and expanded, and then used to guide data collection in future research. It is also important to note that the ratings, to the extent they are valid, represent the conditions that existed when the data were collected in this study (1993 - 1994).

Table 3 shows that most of the case study sites have developed, or are developing, many of the components and subcomponents of the family violence intervention model.

The overall study results revealed that despite the significant efforts that are being made by many individuals and organizations, the net results are inadequate to the task: too often women, children, and the elderly suffer repeatedly and for long periods of time at the hands of abusers-batterers-neglecting parents or guardians. What is needed is a "paradigm shift" in the approach to combatting family violence. The heart of this paradigm shift should involve:

- Recognition of the scope of family violence on the reservation or community
- Commitment by significant segments of the tribe or community to control family violence
- The systematic adaptation and application of the family violence intervention components identified in the case studies.

**Table 3. Ratings of the Four Case Study Sites on the Components
of Family Violence Prevention Initiatives**

Family Violence Intervention Components	Warm Springs	Cherokee	Navajo	Rosebud
1. ADOPTION OF FAMILY VIOLENCE CODE				
a. Commitment of tribe to prevent and decrease family violence	P	D	P	P
b. Mandatory arrest for probable cause	DK	A	D	P
c. Mandatory treatment or incarceration for batterers	D	A	D	A
d. Anti-stalking law	DK	A	A	A
e. Banishment from reservation for repeat offenders	D	A	DK	A
2. ESTABLISH VICTIM SUPPORT SYSTEM				
a. Shelters on and off reservation	P	P	P	P
b. 24-hour telephone hotline	P	P	P	P
c. Emergency transportation to shelter or medical facility	M	P	P	P
d. Victim Support Groups	M	D	P	P
e. Long term housing and subsistence program	A	A	A	DK
f. Family therapy	M	A	P	DK
g. Interagency protocol—resource list	D	D	DK	DK
3. POLICE PROCEDURES AND TRAINING: VICTIM ASSISTANCE PROTOCOL				
a. Responsibility for victim protection	P	A	DK	D
b. Incident reporting and documentation	P	A	D	D
c. Testimony and case follow-up	D	A	DK	D
d. Sensitivity training	DK	A	A	A
e. Utilization of women officers	DK	A	DK	D
4. COMMUNITY EDUCATION AND INVOLVEMENT				
a. School-based prevention programs	A	D	DK	P
b. Tribal leaders	A	A	P	P
c. Women's support groups	P	D	P	P
d. Men's support groups	A	A	P	A
e. Family support groups	P	A	P	A
f. Traditional values and teachings	P	D	P	D
5. COORDINATION OF RESOURCES AND PROGRAMS				
a. Interagency family violence intervention initiative	D	DK	DK	A
b. Revise or develop family violence protocols				
i. Tribal Programs				
(1) Head Start	DK	DK	DK	DK
(2) CHRs	DK	DK	DK	DK
(3) Alcoholism/Substance Abuse	DK	DK	DK	DK
(4) Social Service	P	P	P	
(5) WIC	A	A	A	A
(6) Health Department	DK	DK	DK	DK
(7) Tribal Courts	D	P	P	D
(8) Legislative	P	P	P	D
(9) Law Enforcement/Tribal Police	D	D	D	D
(10) Employment	A	A	A	A
ii. IHS Programs				
(1) Family violence prevention team	DK	A	P	A
(2) CPTs	P	D	P	P
(3) Mental Health	D	D	D	D
(4) Maternal and Child Health	D	D	D	D
(5) Emergency services	D	D	D	D
(6) Pediatrics	D	D	D	D
(7) OB/Gyn	D	D	D	D
(8) PHNs & CHNs	A	A	A	A

Table 3 (Continued)

Family Violence Intervention Components	Warm Springs	Cherokee	Navajo	Rosebud
iii. BIA Programs				
(1) Law Enforcement & Criminal Investigation	D	D	D	D
(2) Judicial Services	D	D	D	D
(3) ICWA	D	A	D	D
(4) Social Services	D	D	D	D
(5) Education	D	DK	D	D
iv. Other Federal Programs				
(1) FBI	DK	DK	DK	DK
(2) US Attorney	DK	DK	DK	DK
(3) Head Start	A	A	A	A
(4) WIC	A	A	A	A
(5) Court System	DK	DK	DK	DK
v. Other Programs				
(1) State Police	DK	DK	DK	DK
(2) State attorney	DK	DK	DK	DK
(3) County sheriff & police	DK	DK	DK	DK
(4) County social services	DK	DK	DK	DK
(5) County shelters	DK	DK	DK	DK
6. INFORMATION-TRACKING SYSTEM (FAMILY VIOLENCE TRACKING SYSTEM)				
a. Uniform interagency system with core data	A	A	A	A
b. Assign responsibility for maintenance (Police)	A	A	A	A
c. Regular reporting requirements by agency	A	A	A	A
d. Track victims				
i. Location	DK	A	DK	A
ii. Complaints of harassment, stalking	DK	A	DK	A
iii. Ally	DK	DK	DK	DK
e. Track abusers				
i. Location	A	A	A	A
ii. Participation and progress in mandatory treatment	D	A	DK	A
f. Resource list				
i. Shelters	P	P	DK	DK
ii. Potential allies	P	DK	DK	A
iii. Victim support groups	P	P	DK	DK
7. SPECIAL TRAINING INITIATIVES				
a. Police				
i. Victim protection mission	DK	A	DK	DK
ii. Case tracking and follow-up	DK	A	DK	DK
iii. Data recording and management responsibility	DK	A	DK	DK
vi. Interagency police cooperation: tribal, BIA, FBI, County Sheriff	DK	D	DK	D
b. IHS medical staff	DK	DK	DK	DK
8. ABUSER TREATMENT PROTOCOL				
a. Adaptation of successful programs				
b. Regular use of and contribution to a family violence tracking system				
CODES: DK = Don't Know or Information Unavailable M = Model Program Component P = Program Component Present A = Program Component Absent D = Program Component Developing				

The eight components of family violence interventions represent the key findings of the study; each component is discussed, in turn, below.

1. Adoption of Family Violence Code

a. Commitment of the Tribe. Frequently, existing tribal codes define offenses such as assault, battery, child abuse, and neglect. Even when such offenses are codified, the code should be revised to explicitly focus on family violence, state the tribe's commitment to protect the victims and, most importantly, to specify penalties and procedures that will ensure the protection of victims from abusers.

b. Mandatory Arrest for Probable Cause. **Mandatory arrest is a critical feature of the needed paradigm shift.** It is simply unrealistic to expect a victim of abuse or neglect to "press charges" against the abuser. Often the victim is financially, emotionally or otherwise dependent on the perpetrator of abuse or neglect. More importantly, the abuser often threatens the victim with beatings or death if the victim presses charges or testifies against the abuser. It is absolutely critical that the tribe not place the victim at greater risk by requiring the victim to press charges; rather, the tribe should explicitly assume the responsibility for prosecuting the abuser, and for protecting the victim(s). The tribe assumes this responsibility by 1) making spouse abuse a crime, and 2) developing a family violence protocol for the police that mandates arrest of abusers for "probable cause" (e.g., a bruised or bleeding victim, witnesses of abuse present, etc.). Sometimes the victims of abuse will, out of fear, deny that there is any problem. The protocol should call for the police officer to use his/her "gut feeling" in assessing the apparent danger of the situation, and to make an arrest whenever a sense of imminent danger is present.

The protocol for police should include a written report, photographs (of the victim, damage to furniture, walls, etc.), and taped interviews of the alleged abuser and victim. The arrest of the alleged abuser should result in a 12-24 hour detention to allow a hearing on the tribe's complaint of family violence.

c. Mandatory Treatment or Incarceration for Abuser. Before the alleged abuser is released from detention (i.e., within 12-24 hours), there must be a formal hearing that includes testimony of the arresting officers and the introduction of evidence such as a report of a medical examination, and testimony of a victim assistance worker who has interviewed the victim.

If the regular tribal judicial resources are inadequate to support family violence hearings within 24 hours of the arrest of an alleged abuser for probable cause, the tribe should consider redirecting resources to combat this critical problem by creating a family violence emergency hearing master

or panel that can conduct hearings prior to the release of an alleged abuser in accordance with a strict and clearly defined protocol.

If the outcome of the hearing is that the alleged abuser is found to have violated the family violence code, he or she should be required to participate in a treatment program (e.g., batterer treatment). Either refusal or failure to participate in the treatment program should, in accordance with the tribal code, result in incarceration of the abuser.

For abuser treatment to be effective, it is critical for the treatment program to 1) receive detailed information about the violent act(s) committed by the abuser (e.g., the arrest record), and 2) to provide regular feedback to the court about the abuser's attendance, participation, and progress. It is common for batterers to deny perpetrating any abuse or to flagrantly minimize the violent acts. The therapist needs the description of the abuse (e.g., "The victim had a black eye.") in the arrest report and/or medical report in order to effectively confront the abuser's denial. It is also critical that premature termination of treatment by an abuser result in prompt, sure incarceration for failure to comply with the terms of release.

d. Anti-Stalking Law. Abusers and batterers use violence and the threat of violence to get what they want. After the victim has been battered or beaten, the mere threat of violence (sometimes implied by seemingly innocuous signals such as drumming fingers on a table, staring, muttering "oh yea, oh yea") can elicit terror from the victim. An anti-stalking law which prohibits following the victim from place to place, appearing at the victim's school, place of work, or other place, and frequent observation of the victim is needed to reduce an abuser's ability to threaten and torment the victim.

e. Banishment of Repeat Offenders from the Reservation. It is not fair or reasonable that a victim of family violence should be forced to leave his or her reservation to be safe from intimidation or attack by an abuser. In order to ensure the safety and security of victims, abusers convicted of multiple attacks on an innocent victim should be banned from the reservation.

2. Establish Victim Support System

The mission of this support system is the guarantee of reasonable safety and security of victims of family violence.

a. Shelters on and off the Reservation. It is critical that the victim of family violence have access to a temporary shelter where he or she cannot be attacked by the abuser. The shelter should be accessible 24 hours a day, 7 days per week. The shelter should be accessible for stays of sufficient length to allow the victim to secure long term, secure housing. The shelter should provide (or serve

as a conduit for) other services needed by victims of family violence (e.g., counseling, social service, legal aid).

b. 24-hour Telephone Hotline. The primary guarantor of the safety of actual and potential victims of family violence should be the police. The role of the hotline would be to provide quick response information, referrals, and advice to actual and potential victims and perpetrators of family violence. For the sake of efficiency in an environment of scarce resources, the family violence hotline can be integrated with other hotline functions such as suicide prevention.

c. Emergency Transportation to Shelter or Medical Facility. Such transportation should be tightly integrated with the police response to family violence. Examination and medical reports constitute important evidence in family violence legal proceedings. In the context of probable cause, the arresting officer(s) should ensure that the victim has transportation to needed medical attention and, if necessary, to a shelter.

It is not necessary for the police to provide the needed transportation; however, the police should be responsible for ensuring the needed transportation (e.g., an ambulance, vehicle operated by member of the CPT, etc.) is obtained.

d. Victim Support Groups. Such groups are probably best when operated by "grass roots" organizations of volunteers. Such groups can, without the expenditure of large amounts of funds, provide vital emergency and human resources for a wide range of activities including:

- school-based family violence prevention programs
- on-call "allies" much like the sponsors in Alcoholics Anonymous
- on-call transportation of victims and their families to shelters
- peer counselling and support groups for victims and their families.

e. Long-Term Housing and Subsistence. Shelters provide short-term (e.g., 30 days) housing for victims and their families. Long-term housing is needed by victims who, for whatever reason, cannot safely remain in their previous residence.

There are opportunities for the development of creative ways to find or create the needed housing. For example, funding for construction or rehabilitation can be obtained from Federal, state, or local governments, or from philanthropic organizations. The local community college or vocational

school can construct the needed housing. Existing buildings can be modified to serve as housing with significant labor provided by volunteers.

f. Family Counseling. The primary mission of the family violence prevention initiative should be the guarantee of the safety of the victim(s). Only after this mission is assured should family counseling be provided. The elimination of family violence should be a core component of this counseling. Family counseling should never supplant court-ordered treatment for offenders.

g. Interagency Protocol. Active, interagency cooperation and collaboration are critical to the success of family violence prevention initiatives. Most agencies on the reservation should have explicit goals, objectives, and protocols specifying the agency's role in combatting family violence and in supporting victims of family violence. Component 5 deals with the coordination of resources and programs, and expands on this point.

3. Police Procedures and Training: Victim Assistance Protocol

The case studies generally revealed that major changes are needed in the training, roles, goals, procedures, and mission of the police with respect to family violence.

a. Responsibility for Victim Protection. When responding to a family violence complaint or call, the primary mission of the officer (or, preferably, the team of officers) should be the protection of the victim(s). As indicated in Section 1, the protocol should include arrest of the suspected abuser on probable cause as defined in the Tribal Code. The apparent victim should **not** be required to file a complaint. The police officer should be the "point man" with the key responsibility for:

- ensuring the safety of the victim(s)
- arranging for transportation of victims needing medical care or emergency shelter
- collection of evidence
- filing of timely and complete reports as mandated by the Tribal Code
- ensuring that arrangements are made for the victim(s) to receive victim support services.

b. Incident Reporting and Documentation. Proper reporting and documentation will require clear, reasonable, and specific forms and procedures, preferably facilitated by good computer support. The report of a family violence incident should automatically set into action a sequence of events that includes documentation of:

- the date, time, and location of the alleged incident
- the parties involved
- the police officer(s) involved
- the basis of the arrest, if any (i.e., probable cause)
- the method of transportation to medical care, if needed
- the method of transportation to an emergency shelter, if needed
- the victim's assistance "ally" assigned to support the victim(s)
- time alleged perpetrator "booked" and incarcerated
- time of initial hearing
- outcome of initial hearing (e.g., mandated abuser counselling, incarceration pending trial)
- family violence counselor responsible for case or release of victim
- dates and times alleged abuser to attend court-mandated counselling.

Documentation of the complaint should include taking statements from witnesses to the incident, photographs, or other documentation as appropriate.

c. Testimony and Case Follow-up. It was found in each study site that some cases against abusers were dropped because the arresting officers were unavailable at the time of the hearing. This problem can be greatly attenuated by:

- conducting hearings (under the direction of a special family violence hearing officer, if necessary) within 24 hours of the arrest
- making the prevention and control of family violence a high priority among police activities.

Follow-up on complaints of family violence is critical. Generally an abuser does not stop intimidating and abusing the victim(s) as a result of being arrested. In fact the opposite often happens—the abuser becomes frustrated and enraged at being arrested. This rage is displaced onto the victim with a resulting increase in attacks on the victim.

The frustrated and angry abuser does not attack the police or other authority figures; instead the abuser again attacks the victim. In keeping with their mission of protecting the victim(s), the police should systematically follow-up both the alleged victim and abuser. All parties should be aware that additional abuse or intimidation will result in immediate arrest, additional charges, and severe penalties (as specified in the family violence prevention code).

d. Sensitivity Training. At each case study site, more than one informant suggested that the efforts of the police were substantially below the level needed or that the attitude of the police was not supportive of the victim(s) of family violence.

A fundamental change in the attitude, values, and mission of the police is part of the "paradigm shift" needed to successfully combat family violence. Special efforts will be needed to help the police to enthusiastically adopt a protective and supportive orientation toward victims of family violence. The needed training will have a higher probability of success if the tribal leaders adopt a similar stance.

e. Utilization of Women Officers. Several informants observed that most victims of spouse abuse are women, and that few police officers are women. The informants observed that gender disparity might impact on the attitude and actions (or lack of actions) of police with respect to family violence complaints. It was suggested that a male-female officer team might be more effective than either gender alone.

4. Community Education and Involvement

There was a consensus among the informants that without support throughout the tribe or community, family violence prevention initiatives are unlikely to succeed. Six components of community education and involvement emerged from the case studies.

a. Tribal Leaders. Informants suggested that elected tribal leaders, like the police, are sometimes "behind the curve" with respect to family violence—they do not seem to recognize the magnitude of the problem and, consequently, do not provide the leadership needed to produce a "paradigm shift" in the tribe or community.

Some informants observed that tribal leaders, like police, are not immune from committing or being the victims of family violence. Informants stated that it is the responsibility of knowledgeable individuals and groups to educate tribal leaders and to help "energize" elected and appointed leaders into action.

b. School-Based Prevention Programs. Many informants stressed the need to start violence prevention efforts with children, even young children. Such education could begin in pre-school programs such as Head Start. Head Start involves the whole family and includes emotional, social, and physical as well as educational aspects of child development.

Age appropriate educational materials for elementary, middle, and high school students should be developed or adapted for students in the reservation or community. Such materials might include the tribal code, positive traditions, the role of shelters, ways to prevent and respond to family violence.

As with the other intervention components, to achieve success school-based interventions must have the commitment of the stakeholders in the schools including teachers, administrators, students, and parents.

c. Women's Support Groups. Since women are so often victims of family violence, the women in a community have a special incentive to take constructive action to prevent family violence and to support its victims. A good example of a woman's support group is the White Buffalo Calf Woman Society at Rosebud. Such support groups can lobby for any and all of the needed intervention components. As one informant observed, "one woman can be a spark; 10 women working together can be a forest fire." Women's support groups have instigated much of the awareness of the horror of family violence and the need to fashion successful interventions.

This study suggests that successful efforts for the prevention, intervention or reduction of family violence include coordination of diverse components and programs such as social services, health care services (including mental health), judicial system, law enforcement, education system, tribal council, and shelters and/or foster care facilities (privately-owned, and those funded by Federal, state, and tribal governments). If there is a breakdown in the performance of any of these components, prevention and intervention efforts are weakened.

In order for this network of services to accomplish the desired goals, it is critical to have a clarification of roles and responsibilities, communication, and a comprehensive reporting system. The findings show that if these elements are lacking, the support network is ineffective, and victims may experience confusion and are more likely not to seek help.

d. Men's Support Groups. Men's support groups can complement women's support groups. Since most, but not all, abusers are men, men have a special responsibility to combat family violence. Men's groups can advance any and all components of family violence initiatives. In combatting family violence, men can establish positive role models for other men and for boys.

e. Family Support Groups. The first objective of family violence prevention initiatives must always be protection of the victims. All members of the family are harmed when family violence occurs.

When a mother is battered by her spouse, the children are harmed. When one child is abused, any siblings are likewise traumatized. Family support groups should be focused on minimizing the damage of the abuse on all family members—those affected indirectly as well as directly.

Efforts at re-integrating the abuser with the family should be considered only if two conditions are met: 1) the abuser has successfully completed an abuser treatment program, and 2) the remaining family members desire this re-integration.

f. Traditional Values, Roles, and Teachings. Each tribe has traditions and culture elements that are compatible with protection of the tribe, community, or specific groups such as children. These traditional values, roles, and teachings should be invoked in generating and sustaining community involvement in combatting family violence.

5. Coordination of Resources and Programs

a. Interagency Family Violence Intervention Initiative. Because family violence tends to be a taboo subject, individuals and groups avoid discussion of family violence and fail to directly and explicitly address the problem. The chances of success of an intervention program will be greatly enhanced if every relevant program explicitly focuses on the problem. This focus should include a re-examination of the mission, goals, and objectives of each program with respect to preventing and reducing family violence. Each program should develop protocols to guide program staff in dealing with victims, abusers, and other programs and agencies. Each program should examine its role and responsibilities with respect to each of the eight family violence intervention components discussed in this study.

Developing and maintaining protocols for dealing with family violence and for cooperating with other programs will be critical to the success of a family violence intervention.

The case studies revealed that many programs already include some components designed to detect, treat or refer one or more types of family violence; however, the efforts of individual programs are seldom well coordinated with other programs, and victims often "fall between the cracks."

A few examples of programs listed in section 5 of Table 3 are instructive. The performance standards for the Head Start Program mandate that each child be examined each day for evidence of physical injury (e.g., serious abrasions, cuts, bruises, joint dislocations). Such injuries might have

any number of causes such as accidents or battering. If evidence of injury is discovered, Head Start staff are supposed to inform the appropriate social service agency (e.g., child protection team).

The Head Start performance standards are excellent; nevertheless, Head Start could employ a number of additional activities to enhance its impact on family violence. For example, the issue of family violence could be explicitly addressed in the goals and objectives of the national program, in training offered by the Regional Resource Centers, and in the materials provided to the grantee parent committees.

A second example is the Community Health Representative (CHR) Program. These programs could develop protocols for case finding and case follow-up at the local, tribal, and national levels. Working closely with Service Unit medical staff and the police, the CHR could provide follow-up support to victims of family violence by making home visits and by helping the victim to learn about and to use other victim support services. Often, the victim of family violence is confused and immobilized by the experience. This confusion and immobilization when added to financial and other dependence on the abuser, makes it difficult for the victim to act on the advice offered in a single encounter (e.g., with medical staff at the Service Unit). In providing follow-up support, the CHR can meet with the victim repeatedly over a period of time to provide the support the victim needs to overcome the confusion and immobilization caused by the abuse.

It is important to note that the two programs discussed in this section on "Coordination of resources and programs" (Head Start and CHR) are only examples. Similar examples could be developed for each of the programs listed in section 5 of Table 3. The case study data suggests that a family violence prevention initiative should involve the active cooperation of all the programs listed in section 3.

The various components of the family violence initiative must improve their liaison with other organizations explicitly with respect to family violence. For example, training, resources, and cooperative protocols could be shared with the local IHS Service Unit, the tribal alcohol and substance abuse program, and the tribal IHS program. All these programs share a health promotion and disease prevention approach and the prevention of family violence is, or should be, a direct or collateral objective. Nevertheless, active planning, cooperation, and collaboration among these programs are rare. The lack of cooperative planning and collaboration is not restricted to the programs named. What is needed is commitment by leaders from the tribe, IHS, BIA, and other programs to foster cooperation and collaboration with respect to specific program goals. The leaders' commitment must be supported by corresponding changes in such things as 1) the performance

review criteria for program managers to reflect active cooperation in the family violence prevention activities, and 2) the allocation of program resources. Finally, care must be taken to ensure that the lines of responsibility are not blurred, that the efforts to increase cooperation do not result in diffusion of responsibility. To this end, each program should develop clear, explicit, and measurable objectives so that its performance in the area of family violence can be validly evaluated.

6. Information Tracking System

Some data relevant to family violence exist in many different information systems; however, the data in these information systems are generally difficult to access, even for the personnel of the agency controlling the system. It is almost impossible for staff of other organizations to access an agency's data. This lack of information sharing can lead to catastrophic consequences for victims of family violence. For example, if a woman seeks treatment from an IHS clinic for injuries received at the hands of a batterer-spouse, the police (tribal, BIA, or other) may or may not be notified. If the police are notified, it is unlikely that they will receive a standard spouse abuse report. It is almost certain that the police will not receive an electronic communication that sets into action a quick response designed to protect the victim (and others in the family) from future battering or worse. If the police do receive notification of the incident, it is almost certain that they will lack an information system that permits them to quickly determine if the batterer has a history of such offenses.

It is similarly unlikely that other agencies will be automatically informed of the incident. Head Start and school officials will not be alerted to increase their vigilance with respect to the children in the batterer's household. Tribal or BIA social service staff will not be alerted to put into play a victim support protocol—both because these agencies will not be informed and because they lack explicit victim support protocols.

Assume that the abuser in this scenario is an alcoholic and attends, with some regularity, counselling sessions at the tribal Alcohol and Substance Abuse Program. Will the program counsellors be informed? No! If they were informed, would they have a protocol to guide their working with the batterer? No! Are we likely to see a decrease in family violence without such protocols and information sharing? No!

a. Uniform Inter-Agency Information System. Such a system would be greatly facilitated if the many relevant agencies had a shared capability such as electronic mail (E-mail). Agency staff with access to a personal computer on a local area network (LAN) could send and receive E-mail from their own LAN to other LANs by means of bridges or routers (PCs that interconnect LANs). The technology

for the LANs, E-mail, and routers has been available for several years. However, it is not necessary to design and implement such a system to support the needed interagency information system. Such a system can be developed using:

- specially designed paper forms
- faxes
- telephones
- explicit protocols.

For example, consider the following scenario. A 24 year old woman is seen at the Service Unit clinic. She has not come to the emergency room, but complains of chest pain and coughing up blood. The physical examination reveals hairline fractures of her ribs, serious contusions about her ribcage and right eye. Given the patient's vague explanation of the cause of her injury, the examining physician follows the "battered patient" protocol and, in accordance with the family violence training he/she has received, the physician:

1. provides support and reassurance to the patient
2. completes the examination in accordance with the protocol taking care that the results of the examination can be used in court
3. ensures that the patient, who has admitted that she was battered by her spouse, is accompanied by a staff member trained in the support of victims of family violence.

Before the patient has left the hospital, the police, social service, family prevention team, and other groups have been informed. The police arrests the alleged batterer on probable cause, and the victim receives on-going support from an "ally" trained in supporting battered spouses. A core set of data such as the name, addresses, and telephone numbers of the victim(s) and alleged abuser(s), date of the incident(s), description of the injuries, and the names of agency staff assigned to the case will greatly facilitate implementing family violence initiatives.

b. Assign Responsibility for Maintenance. For the information tracking system to work, some agency should assume responsibility for the maintenance of the data. Given their critical role in preventing family violence (the police officer is often the first person on the scene), the police are a good candidate for this responsibility.

Furthermore, it is important for the police to know if the alleged abuser has previously been arrested for committing acts of family violence so that this information is available to the court when the hearing is conducted. It is important for a batterer or potential batterer to know that the police and

other authorities will know his/her prior history of abuse, and that this prior history will have a profound impact on his/her hearing.

c. Regular Reporting Requirements by Agency. Reporting requirements become meaningful once each relevant agency establishes goals and objectives regarding the prevention and reduction of family violence, and has developed corresponding protocols. In developing or enhancing the family violence prevention program, each agency should specify the actions, events, and activities to be reported. For example, the Tribal Health Department might report the:

- number of cases "discovered" or "found" in the tribal clinic,
- the number of cases reported or referred to the program by other programs (e.g., tribal police, CHR Program, Head Start, etc.),
- the disposition of both types of cases (e.g., abuser arrested, family moved to a safe house).

These reports should be shared with selected other groups (e.g., Family Violence Prevention Team, Tribal Council) as well as the appropriate line of authority.

d. Track Victims. The purpose of this component of the family violence tracking system is to help ensure that the victim does not "fall between the cracks" of the safety and support net. Some "double checking" should occur. For example, when the police made an arrest for probable cause, an ally (a lay person training in supporting victims of family violence) should be assigned to the case. In addition, reports and data requests should be made to the other relevant agencies (e.g., IHS Service Unit, CHR Program, tribal Social Service Program). Someone (perhaps a CHR or the ally) should be charged with the responsibility of following up with the various agencies involved to ensure that the appropriate follow-up has been initiated and the specified steps are being carried out.

Of course, to ensure the safety of the victim(s), it is imperative that the abuser not gain access to information about the victim(s). The safety of the victim(s) must be of paramount importance in all aspects of family violence prevention initiatives.

e. Track Abusers. It is important that abusers understand that **any** efforts to further harass, intimidate or abuse the victim(s) will be quickly discovered and will result in immediate re-arrest and detention. Tracking and monitoring known abusers should be proactive rather than reactive. For example, either a police officer or a case worker should physically meet with the abuser on no less than a weekly basis. The follow-up should include confirmation that the abuser is participating in good

faith in the court-ordered treatment program. It is important that the abuser understand that the tribe or community has an on-going interest in the safety of the victim(s).

f. Resource List. The resource list is an important component of the family violence information tracking system. The case studies revealed that some informants were often unaware of the availability of various resources. The availability of resources should be published periodically, and lists of resources should be maintained and updated by all relevant agencies. For example, all the programs should maintain a list of shelters and other agencies that support victims of violence. More importantly, the family violence prevention protocol for each agency should specify which other agencies should be contacted, who should be contacted, and how the information should be conveyed.

The resource list should include a list of allies (lay or other persons trained in supporting victims of family violence) that can be called on a 24-hour basis to support victims.

7. Special Training Initiatives

The staff of most agencies do not know how to deal effectively with either victims or abusers. The need for training in the area of family violence in many ways parallels the need for training in the area of alcoholism and substance abuse. While the staff of each relevant agency should receive the needed training, the training needs of three groups were especially clear in the case studies: the police, IHS medical staff, and allies.

a. Police Training. As previously stated, the police officer is often the first authority on the scene during or after an incident of family violence. The actions of untrained police can easily and greatly exacerbate the problem.

The police officer needs to have a protocol specifying steps to be taken when confronting family violence. In addition, the police need to receive training in using the protocol, training provided by experienced experts in family violence prevention. Key elements of the training for police include:

- use of role playing
- the primacy of the goal of protecting the victim(s)
- ensuring support for the victim(s)
- collecting evidence required by the court
- providing the testimony needed by the court

- data reporting requirements
- interagency cooperation and coordination.

b. Medical Staff (IHS or Tribal). While medical staff often do a good job of treating the injuries of a victim of family violence, they often do a poor job in 1) identifying family violence as a cause of injuries, 2) making the appropriate referrals for victims, 3) providing the appropriate follow-up care, 4) obtaining the type of evidence needed by courts in the prosecution of abusers, and 5) in providing the expert testimony needed by the court. Medical staff need training by experienced experts in all these areas.

The medical staff training should incorporate the recognition, crisis intervention, and referral requirements of the Joint Commission for Accreditation of Health Organizations (JCAHO) as well as the Diagnostic and Treatment Guidelines on Domestic Violence developed by the American Medical Association.

Each Service Unit should have a physician trained in conducting special examinations needed for victims of rape and child sexual abuse. In addition, medical staff should receive special training on providing emotional support designed to minimize the psychological trauma associated with such assaults.

The IHS needs to work with the police and an interagency family violence prevention task force to develop a core data set and a reporting system so that issues of confidentiality do not prevent the flow of information needed to protect the victim(s) and to prosecute the persons who commit violence against the members of their family.

c. Ally Training. Victims of family violence need someone they can confide in and seek support from. Organizations like Alcoholics Anonymous have developed a similar role—the sponsor. The sponsor is a person the alcoholic can call any time, any day, when he feels he is tempted to "fall off the wagon." Victims of family violence need and deserve no less of a support system. Like the sponsor, an ally should be able to respond to the victim any time, any day, should the victim feel he/she is being threatened, stalked, or intimidated by the abuser. Also like the sponsor, the ally can be a lay person who has received special training; successful experience in dealing with an abuser would be helpful, and training to become an ally could be a valuable part of the healing process for victims of family violence.

8. Abuser Treatment Protocol

Surprisingly, abusers receive little or no treatment. Generally abusers deny committing family violence, police often fail to arrest the abuser and, if arrested, the courts often fail to successfully prosecute the abuser. Even if arrested, convicted, and sentenced to participate in therapy, abusers often terminate treatment without sanction or any follow-up by the authorities.

Even if the abuser does participate in some type of treatment, the therapists have little training in the treatment of batterers, rapists, or pederasts. If family violence is to be prevented and decreased, all this must be changed—convicted abusers should be sentenced to treatment in lieu of incarceration. The therapists must be given documentation about the violence committed so that the abuser's denial can be confronted. The abuser's active participation in treatment should be routinely reported so that the abuser's failure to participate results in certain incarceration.

a. Adoption of Successful Programs. Working closely with other organizations involved in the family violence prevention initiatives (e.g., police, courts, women's shelters), the IHS should develop abuser treatment programs modeled after similar successful programs. The IHS Mental Health and Alcohol/ Substance Abuse Programs should collaborate in this effort.

b. Regular Use of and Contribution to a Family Violence Tracking System. Almost always perpetrators of family violence deny any wrong doing. Such denials are made publicly despite overwhelming evidence. Therefore, it is important that therapists have access to relevant portions of court proceedings, medical examinations of the victim(s), and other material in order to be able to confront false denials by abusers in treatment. Conversely, it is important for the therapist to promptly inform the court should a convicted abuser terminate treatment or to completely refuse to cooperate in the treatment program.

Therapists providing treatment to abusers should successfully complete training for dealing with both victims and perpetrators of family violence such as Project Medicine Wheel and the Duluth Model for Batterer Treatment.

C. Summary of Individual Case Studies

Attachments 1-4 present the individual reports for the four case study sites. This section summarizes some of the information in each report. The sites are presented in alphabetical order.

SITE 1: The Confederated Tribes of Warm Springs. Located in north central Oregon, the Warm Springs Reservation covers an area of over 600,000 acres and is bound on the east by the Deschutes River and on the west by the Cascade Mountains. The reservation was formed by the Treaty of 1855 and is home to Wascos and Sahaptin speaking bands of the Upper and Lower Deschutes, Warm Springs, and Paiute Tribes. They are collectively referred to as the Confederated Tribes of Warm Springs. There are approximately 3,384 enrolled members, and 80-85 percent reside on the reservation.

The majority of informants indicated that general and family violence are both perceived to be significant problems in Warm Springs and occur at about the same rate. Citing the specific types of violence, the majority of informants indicated that both wife abuse, and child sexual abuse were big problems, followed closely by child abuse. Elder abuse was also cited as a problem although on a smaller scale. Figure 3 presents the most commonly reported types of family violence.

Programs and resources available to the Warm Springs Reservation were judged by informants as average to excellent; however, access to those resources is somewhat limited. The most frequently used resources are the Tribal Victims Assistance Program, Family Preservation Program, and community counseling. Shelters are located off the reservation, with transportation and funding provided through the Victims Assistance Program. Cultural isolation was cited as a problem in placing victims and their families in shelters off the reservation. Informants also cited problems with the court, investigative procedures, sentencing, and treatment for perpetrators.

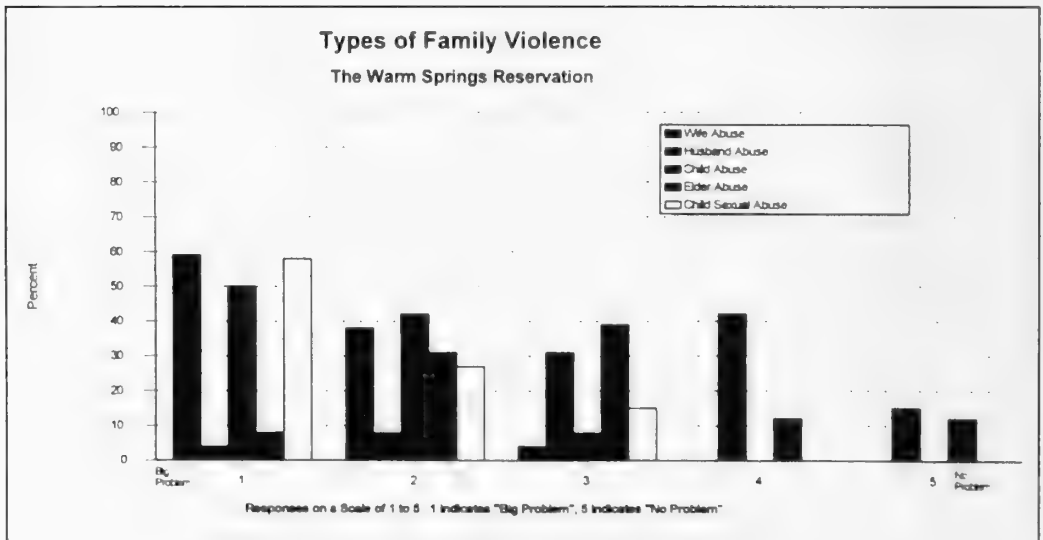


Figure 3. Types of Family Violence, Warm Springs Reservation

Major recommendations from the Warm Springs informants included: 1) education and training for the law enforcement division and physicians, 2) community outreach and networking of programs and organizations, 3) school-based programs for early intervention, 4) modification of judicial services with treatment and rehabilitation provided for perpetrators, and harsher sentences for repeat offenders, 5) coordination of services, and 6) counseling, case management, and follow-up.

SITE 2: Eastern Band of Cherokee. Located in western North Carolina, the Cherokee Reservation is chartered by the state of North Carolina, and is federally recognized. The reservation comprises 56,573 acres. Currently there are 10,320 enrolled members, 66 percent of whom live on the reservation.

The majority of informants did not rate family violence as a big problem on the Cherokee Reservation. The most commonly reported types of family violence were child sexual abuse, followed by wife abuse, and child abuse (see Figure 4).

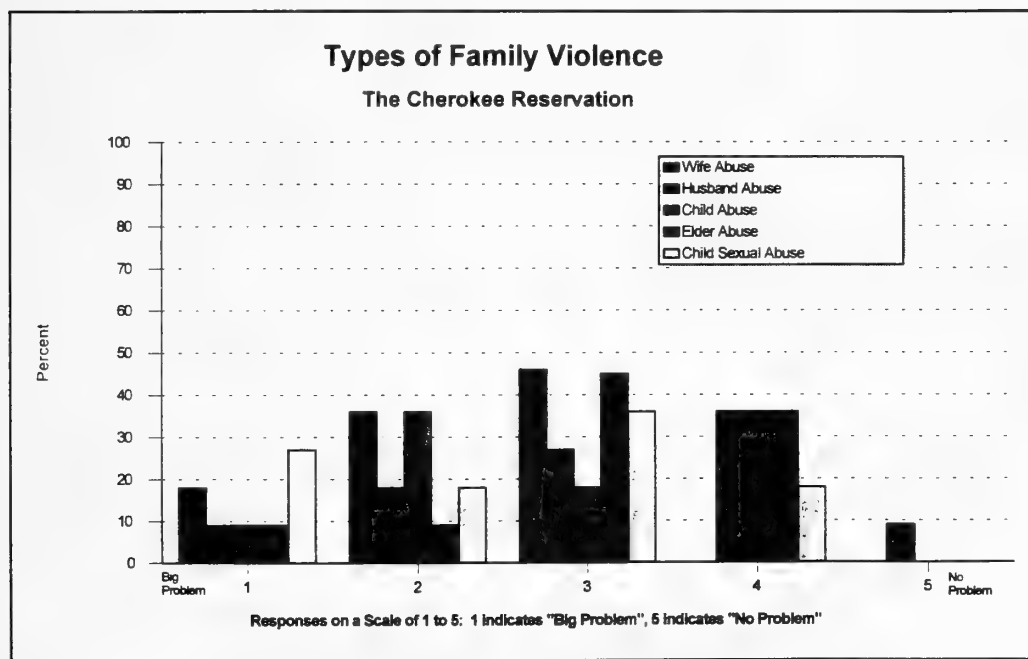


Figure 4. Types of Family Violence, Cherokee Reservation

Most of the programs and services designed for victims of family violence focus on crisis intervention. The two most frequently used programs were the SAFE shelter located in Bryson City,

North Carolina serving both the Cherokee Reservation and Swain County, and the Children's Home, which is located on the reservation. All informants stated there is a need for prevention programs which focus on education and awareness training for the community, and the K-12 school system.

The informants indicated that major obstacles in addressing family violence include 1) denial by the community, 2) acceptance of violent acts as "normal" behavior (this dynamic is reinforced when young children experience abuse as well as witness a parent and/or sibling being abused), and 3) law enforcement personnel who are viewed as being ineffective with respect to family violence.

SITE 3: Navajo Nation. The Navajo Nation is the largest reservation in the United States. It consists of 26,000 square miles, and spans sections of four states. There are approximately 200,000 members of the Navajo Nation. According to the 1990 census, 151,000 members live on the reservation, and the remainder reside in the border areas of the reservation.

The majority of informants indicated that both general violence and family violence are big problems on the reservation. Tribal Resolutions state that "domestic violence is occurring on the Navajo Nation in epidemic proportions. Many Navajo persons are beaten, harassed, threatened or otherwise subjected to abuse within the domestic setting..." Figure 5 shows the most commonly reported categories of family violence on the reservation are wife abuse, child abuse, and child sexual abuse. Elder abuse was also reported as a problem, primarily through "dumping" and neglect.

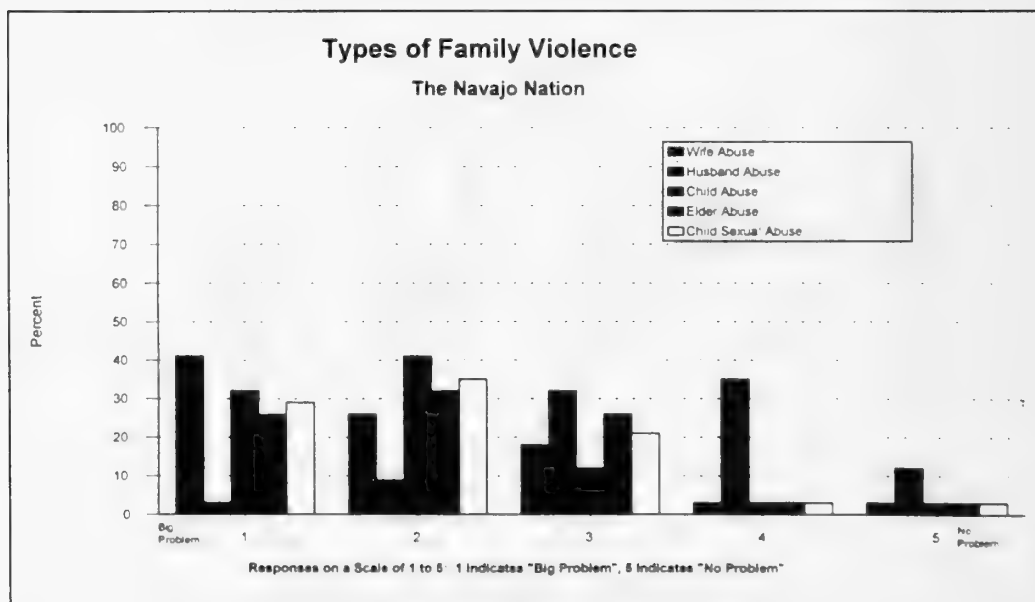


Figure 5. Types of Family Violence, the Navajo Nation

A number of informants indicated that there are two commonly practiced behaviors that impede efforts for the prevention/intervention of family violence on the Navajo Nation. They are 1) denial of the problem, and 2) the belief that the victim "probably deserved" the violent act by the perpetrator. In addition, members of the law enforcement division are viewed by many Navajos as being ineffective in resolving domestic disputes and violence.

There are a variety of programs and services available to the Navajo victims of family violence. For example, there are three shelters on the reservation, and additional shelters located off the reservation; crisis centers and treatment programs exist; legal services are provided through a private legal services program; and counseling is available for male and female groups. Despite this variety of services, there is need for additional programs and resources. The vastness of the reservation, and isolation of many people make access to services difficult.

In July 1993, the Navajo Nation enacted the Domestic Abuse Protection Act. This Act states that domestic violence is a crime, specifies that protection is to be provided for all populations (i.e., children, adults, elders, disabled persons), outlines services for victims, and specifies penalties for perpetrators. Major recommendations from the Navajo informants included 1) education/training (in-service training, school-based programs, community-based programs, alcohol and substance abuse treatment programs, etc.), 2) strengthen law enforcement efforts, 3) coordination of program and agencies, 4) develop reporting systems, and 5) return to traditional values.

SITE 4: Rosebud Sioux Reservation. Located in south central South Dakota, the Rosebud Reservation is 200 miles from any major city in any direction. The population of the reservation is 13,050, with an additional 1,722 living adjacent to the reservation. The unemployment rate was reported to be 89 percent.

The majority of the informants indicated that both general violence and family violence are big problems on the reservation. As shown in Figure 6, the most commonly reported categories of domestic violence included child abuse, wife abuse, child sexual abuse.

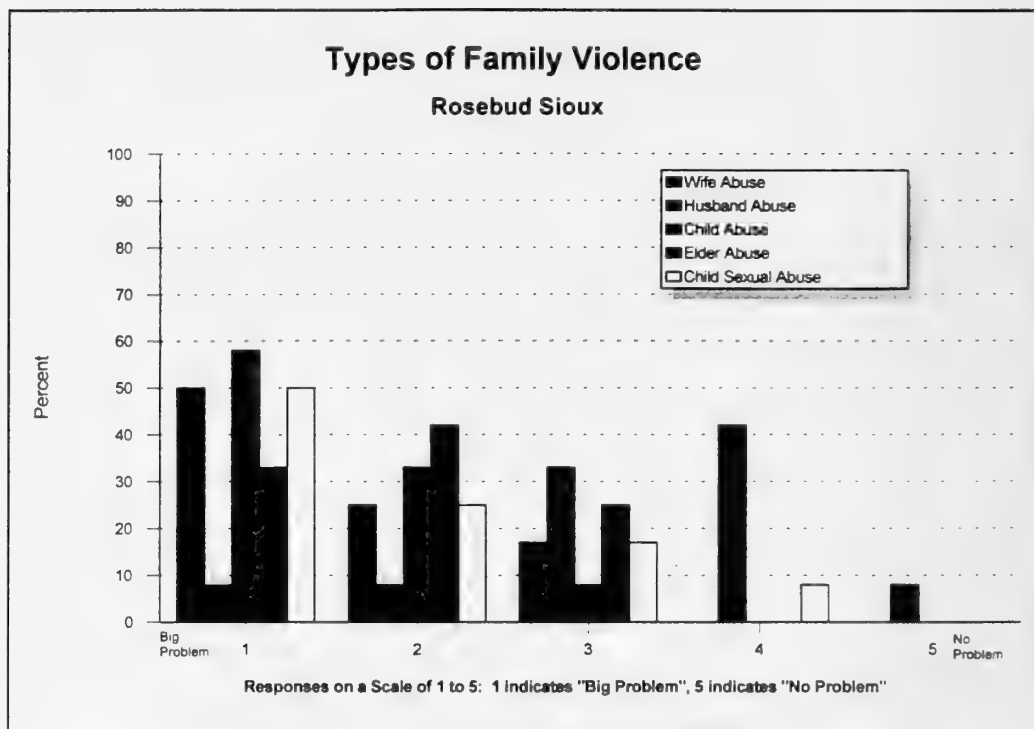


Figure 6. Types of Family Violence, Rosebud Sioux Reservation

There are shelters and family crisis programs and services available to members of the Rosebud Reservation; the majority of these facilities are privately owned. In addition, there is an interdisciplinary Child Protection Team in place. Most informants indicated there is a critical need for additional programs and efforts to prevent family violence, and that there is widespread community acceptance of violence, both in the home and in the community. Many people were said to be quick to rationalize bad behavior. For example, if a man beat his wife, many reservation residents would conclude that the wife probably deserved it. Most informants indicated that changing this acceptance of family violence would be a major milestone in preventing violence.

Other informants indicated that family violence issues are not likely to be resolved until the roots of the problem are addressed. They further indicated that poverty, high unemployment rate, loss of tribal identity, and discrimination influenced the level of family violence.

Recommendations for the prevention of family violence include: 1) training/education involving community awareness campaigns, K-12 school programs, men's support groups, teen/youth

programs, preferably conducted by culturally sensitive counselors; 2) coordination of agencies and services including clarification of roles and responsibilities, improved communication, and coordinated reporting and follow-up by the primary agencies; 3) youth programs and services incorporating cultural awareness exercises; and, 4) returning to traditional values utilizing intergenerational sharing of values, and support from community leaders.

D. Barriers to Addressing Family Violence

1. Denial of the Problem

Virtually all forms of family violence were taboo subjects in each of the four study sites. Informants rated that 20 years ago, drinking and alcoholism were taboo subjects in Indian communities. Only after persistent efforts have members of the community become able to discuss the problem publicly. Similar efforts will be required to make it possible to publicly acknowledge and combat family violence.

2. Rationalizing Violent Behavior

"Blaming the victim" was said to commonly occur at each study site. There is a common view in the reservation communities that if a woman or child is battered, they probably deserved it. The success of family violence prevention depends on replacing these views with views that family violence is illegal and wrong.

3. Treatment for Perpetrators

The informants reported that most batterers and abusers do not receive adequate treatment, and they receive virtually no follow-up care. Until perpetrators of family violence 1) are acknowledged by the community as violators of the community laws and standards, 2) are incarcerated for abusing family members, and 3) receive treatment designed to change their attitudes, values, and behavior, little progress in preventing family violence is likely to occur.

4. Conflicting Loyalties

Tribal members, tribal employees, court personnel, law enforcement officers, and other community service workers often know or are related to the perpetrators as well as the victims. Tribal members are often reluctant to testify or speak out against a member of their family, or a friend of the family.

Some of this reluctance can be overcome by the community committing to the protection of victims of family violence by implementing a family violence prevention code. If this code is developed in conjunction with standard procedures such as arrest for probable cause, the reluctance to testify against relatives can be mitigated.

5. Lack of Positive Role Models

Children are often lacking positive role models and father figures. The head of many households are often women. This situation has been occurring for several generations in some families. In some cases, both parents may be affected by alcohol or substance abuse, and younger children in the household are made responsible for siblings.

IV. RECOMMENDATIONS

Based on the study results, nine recommendations are proposed.

1. Redirection of Priorities and Resources

In the context of the rationed health care provided by the IHS, most studies seem to conclude that additional resources are needed to achieve the desired end. This study is no exception—it is clear that additional resources are needed to enhance efforts to prevent family violence. As important as more resources is the need for a recognition of the scope of the problem and of the damage created by family violence. All parties involved, the tribes, IHS, BIA, states, and counties must focus on the problem, and make the prevention of family violence a priority.

2. Education/Training

In-Service Training. Special training for "front-line" agencies and programs (e.g., police officers, IHS, medical staff, judicial services, social services, mental health, counseling, etc.) is needed. This should include interdisciplinary training, and focus on the roles and responsibilities of all agencies and parties involved. The need for cooperation among all agencies and personnel should be stressed. Specialized training for physicians is needed in conducting medical examinations of abuse victims, as well as legal protocol in testifying as an expert witness in abuse cases.

School-Based Programs. Early intervention programs designed for the K-12 school system should be implemented. The program should focus on issues related to family violence (e.g., identification, behaviors, prevention, and resources for dealing with the problem).

3. Community-Based Programs

Alcohol and Substance Abuse Treatment Programs. Programs focusing on treatment for alcohol and substance abuse should include, as a key component, initiatives to prevent family violence. Alcohol was cited as a factor in cases of family violence in each study site.

Parenting Programs. Parenting skills are needed by teen parents, as well as by older parents. Parenting programs can be offered in the schools as well as through other supporting organizations and shelters. The programs can offer support groups, provide a valuable referral service to other resources, and address other forms of family violence in addition to child abuse and neglect.

Family Services. Often programs focus treatment efforts toward one family member in a specific age group. Working within the framework, the program only treats this one individual who subsequently returns or is returned (in case of a minor) to a dysfunctional environment. By working with the family, dynamics within the family can be altered and the cycles of violent behavior can be broken. Follow-up procedures are a critical part of this process.

4. Coordination of Programs/Services

Reservations often have a diverse mix of tribal, Federal, state, and county programs, each with its own guidelines, procedures, protocols, and jurisdiction. Multiple and conflicting protocols and procedures cause confusion for victims of family violence. Often this confusion will result in the victims not seeking or obtaining the needed help. In addition, victims often become second priority, while the conflicts involving jurisdiction and responsibility are resolved.

There is a need to develop 1) an agreement on the division of labor, roles, and responsibility, 2) a coordination plan that is reflected in a reporting system, and 3) reporting and evaluation procedures.

5. Reporting Systems

Each of the various agencies (tribal, Federal, state, and county) with programs addressing family violence maintains some level of reporting. Often these systems are agency- division-specific, and

do not include a tracking system for follow-up activities. There is a need for an accurate reporting system that integrates the various records maintained by each agency or program.

Reporting procedures should be comprehensive and clearly presented in written form to all employees who are likely to encounter family violence. Often the procedures are vaguely understood, or understood, but not written. Staff should be familiar with issues of confidentiality, maintaining patient records, and reporting.

6. Law Enforcement

In-service training is needed for law enforcement staff. Across all study sites, informants reported that law enforcement was the "weak link" in the network of agencies addressing family violence. Appropriate modification of the tribal code, development of family violence prevention procedures, and in-service training for the police should enable police officers to assume active leadership in the protection of victims.

V. CONCLUSION

Every day on some reservation, a batterer known to the community continues to commit acts of violence without being arrested or even detained and questioned. It is as if the abusers were invisible, as if battering a family member were an activity acceptable to the community.

To paraphrase one of the informants: A growing number of voices are saying that family violence cannot be allowed to continue. These voices demand that every person of decency join the chorus, and work to eliminate family violence from our communities. Tribal communities must be willing to undergo self-examination, examining which community behaviors perpetrate the violence against women and children. This social change process is critical to the survival of tribal cultures throughout Indian country.

INDEX

- alcohol and substance abuse 9, 36, 37, 46, 50
- American Indian communities 1, 12, 17, 7, 12, 13
- American Indian 1, 3, 12-18, 1, 4, 6-8, 10-13
- assault 4, 21, 24, 28, 3, 13, 2, 10
- assault rates 10
- BIA 1, 2, 4, 9, 13, 18, 20, 27, 36, 37, 49, 10
- Bureau of Indian Affairs 1, 13
- Cherokee 1-4, 16, 18-20, 22, 24, 26, 27, 44, 45, 54
- Children's Home 45
- child abuse 1, 9, 12, 14, 15, 19, 22, 28, 43-46, 50, 1-3, 5-7, 10-12, 14-17, 2, 10
- child neglect 1, 12, 10
- child protection teams 2, 18
- community awareness 47, 5
- community-based programs 9, 46, 50
- community counseling 43
- Confederated Tribes of Warm Springs 1-4, 16, 18-20, 43, 53
- culturally sensitive counselors 48
- data collection guide 4, 20, 18, 1
- denial 29, 42, 45, 46, 48, 2
- diagnoses of violence 10
- domestic violence 8, 17, 41, 45, 46, 8, 10-12, 14
- Eastern Band of Cherokee 1-4, 16, 18-20, 44, 54
- education 2, 6, 9, 14, 16, 26, 27, 33, 34, 44-47, 49, 8, 17, 10
- elder abuse 1, 3, 5, 12, 16, 18, 21, 22, 43, 45, 16, 2, 10
- emergency 2, 6, 16, 17, 26, 28, 30-32, 38, 9, 10, 12, 14
- emotional abuse 1, 12, 15
- employment 2, 16, 26, 10
- extended family 12, 13, 15, 12
- Family Preservation Program 43
- Family Services 9, 50
- Federal reporting 14
- general violence 4, 21, 24, 45, 46
- health care providers 2, 16
- homicide 4, 13, 17, 21, 24, 4, 9, 13, 14, 2, 10
- homicide rates 9, 10
- intergenerational 13, 48
- in-service training 9, 10, 46, 49, 51
- isolation 15, 43, 46, 10
- judicial services 2, 9, 16, 27, 44, 49
- judicial systems 10
- key informants 1-4, 16-18, 20
- labor force 15, 10
- law enforcement 2, 10, 16, 17, 26, 27, 34, 44-46, 48, 51, 4, 6, 10
- medical 2, 5, 6, 8, 9, 17, 26-32, 36, 40-42, 49, 4, 5, 7, 8, 10-12, 14, 16, 17, 10
- mental health 2, 9, 14, 18, 26, 34, 42, 49, 1, 2, 5-8, 10, 11, 13, 16, 7
- Navajo Nation 1-4, 16, 18-20, 45, 46, 55, 4
- Navajo 1-4, 16, 18-20, 22, 24, 26, 27, 45, 46, 55, 4, 5
- neglect 1, 5, 9, 12, 16, 19, 28, 45, 50, 3, 7, 9-11, 14-17, 10
- non-reservation 15
- nuclear family 12, 15
- parenting programs 9, 50
- parenting skills 9, 13, 50
- passive neglect 16
- perpetrator 28, 32, 46
- perpetrators 14, 30, 42-44, 46, 48
- physical abuse 1, 2, 6
- population 19, 21, 46, 8-10
- prevention 1, 6-10, 12, 14, 16, 20, 26, 30-34, 36-42, 45-51, 1-5, 7-10, 12, 13, 16, 17, 3, 8
- prevention/intervention 46, 8
- protocol 3, 6, 8, 9, 19, 26-29, 31, 37, 38, 40, 42, 49, 10, 11
- qualitative 3, 18, 24
- referrals 8, 30, 41, 4, 6, 7, 10
- reservation communities 1, 12, 15, 48
- role models 34, 49
- Rosebud 1-4, 16, 18-20, 22, 24, 26, 27, 34, 46, 47, 56, 17
- Rosebud Sioux Tribe 3, 19
- SAFE shelter 44
- school-based programs 9, 44, 46, 50
- secondary data 1, 3-5, 16, 19-21
- sexual abuse 1, 3, 8, 12, 14, 15, 18, 19, 22, 41, 43-46, 1, 2, 5, 11, 13, 15, 2, 10
- sex crime rates 10
- shelters 2, 4, 6, 9, 16, 18, 20, 26, 27, 29, 30, 34, 40, 42, 43, 46, 47, 50, 8, 4, 6, 7
- social abuse 16
- social services 2, 9, 16, 27, 34, 49, 1, 3, 7
- specialized training 9, 49
- spousal abuse 15, 16, 1, 2, 12
- spouse abuse 1, 3, 12, 18, 28, 33, 37, 1, 10
- suicide 4, 13, 14, 17, 21, 24, 30, 1, 4, 6, 9, 2, 10
- suicide rates 1, 9, 10
- suspected/reported cases 10
- teen/youth programs 48
- treatment programs 9, 42, 46, 50
- Tribal court 10
- unemployment rate 46, 47
- unstructured interviews 1, 2, 4, 16, 17, 20, 21
- victim 5-8, 26-33, 36-42, 46, 48, 10, 14
- Victims Assistance Program 43
- violent behaviors 1, 12
- Warm Springs 1-4, 16, 18-20, 22, 24, 26, 27, 43, 44, 53
- youth programs 48

ATTACHMENT 1

CONFEDERATED TRIBES OF WARM SPRINGS CASE STUDY REPORT

A CASE STUDY OF FAMILY VIOLENCE IN FOUR NATIVE AMERICAN COMMUNITIES

CONFEDERATED TRIBES OF WARM SPRINGS

I. INTRODUCTION

Support Services International, Inc. (SSI) under contract with the Indian Health Service (IHS) conducted a case study on family violence on American Indian reservations. As part of the study, case study site visits were conducted to four geographically and culturally diverse Indian communities. The sites included the Rosebud Sioux Tribe, the Confederated Tribes of Warm Springs, the Navajo Nation, and the Eastern Band of Cherokee.

The purpose of the site visits was to collect primary and secondary data concerning 1) the prevalence of family violence, 2) the factors perceived to influence family violence, and 3) the intervention/prevention measures in place and/or under consideration. Secondary data were obtained from tribal programs, the IHS, the Bureau of Indian Affairs (BIA), state and other programs.

This case study report is a summary of the site visit conducted at the Confederated Tribes of Warm Springs Reservation. It is important to note that while no single reservation or community is representative of any other, the results of this site visit should be of value as a case study of family violence in American Indian communities.

II. METHOD

The four case study sites were selected using the following criteria: 1) geographic and cultural diversity, 2) willingness of the tribe to participate in the study, and 3) availability of relevant data.

Once the tribe agreed to participate, a point of contact was established. Through a joint effort a site visit protocol and itinerary were developed for on-site data collection.

Data were collected through 1) unstructured interviews with key informants including representatives from tribal, Federal, state, and other programs, and 2) review of secondary data sources. A discussion of each data source is presented below.

A. Unstructured Interviews of Key Informants

Representatives from tribal and other programs focusing on family violence (e.g., social services, mental health, judicial, law enforcement, medical, and the education systems) were interviewed. Unstructured interviews were conducted with 37 key informants:

- Ramona Baez, Program Coordinator, Victims Assistance Program
- Mary Cicola, Juvenile Officer
- Judith Charley, Director, Community Health Promotion, Human Services
- Corey Clements, Juvenile Investigator, Warm Springs Police Department
- Don Courtney, Chief of Police
- Gerald Danzuka, Associate Judge, Tribal Court
- Anita Davis, Health Educator
- Shawn Gaddy, R.N., Health & Human Services
- Jon Grant, Director, Child Protection Team
- Daisy Ike, Juvenile Coordinator
- Leona Ike, Supervisor, Parole and Probation, Tribal Court
- Tyrone Ike, Public Defender/Legal Advocate, Human Services
- Bob Jackson, BIA Social Worker
- Barbara Jim, Court Clerk
- Foster J. Kalana, Juvenile Probation Officer, Parole & Probation, Tribal Court
- Walter Langnese III, Associate Judge, Tribal Court
- Onite Lumpmonth, Nursing Supervisor
- Mark Matthews, Prosecutor, Tribal Public Safety
- Adeline Miller, Community Health Representative
- Alexandria S. Miller, Warm Springs Police Department
- Saraphina M. Morning Owl, Victims Assistance Adult Advocate
- Nancy Puente, Children's Treatment Coordinator, Community Counseling
- Jim Quaid, Community Counseling
- Julie Quaid, Director, Early Childhood Education
- Kermen Smith, BIA Criminal Investigator
- Cerinna Sohappay, Health Educator
- Lola Sohappay, Chief Judge

- Marcia Soliz, Director, Pre-Employment Programs
- Rick Soures, Assistant Prosecutor
- Carol Stevens, Extension Intern, OSU
- Laura Switzler, Volunteer, Victims Assistance Program
- Charles Tailfeathers, Juvenile Coordinator
- Oswald Tias, Captain, Warm Springs Police Department
- Patty Tulee, Victim Assistance Program
- Henry Walden, IPA, Health Educator, Human Services Department
- Carol Wewa, Health Educator
- Carolyn E. Wewa, Community Health Information Specialist
- Wilson Wewa, Senior Program Representative

Discussions with key informants, ranging from 50 to 90 minutes, were conducted over a 4-day period in November 15-19, 1993. With exception of the Health Educator, each informant was interviewed separately by contractor (SSI) staff. After the interviews were completed, a summary of the information was reported. The summaries were reviewed with the point of contact to obtain comments regarding any errors or omissions. Finally, the draft case study report was submitted to the tribal contact for review and feedback. This document reflects the feedback and information from the tribal reviewers.

B. Sources of Secondary Data

The following documents were collected and reviewed:

- List of Statewide Network of Resources for Battered Women
- Victims Assistance Program Brochure and Description
- Warm Springs Tribal Code, Chapter 362, Conservators and Guardians, Chapters 331 and 202, Restraining Orders and Injunctions, Chapter 360, Juveniles, Part 3: Appearances, 3-1, Eligibility to Practice, Part 2: Judges, Part 4: Preliminary Matters, 4-8 Service of Incapacitated Persons, Section 5-9. Temporary Restraining Order, Section 5-12A. TRO-Abuse Prevention Act ORS 107.700, Section 6-23A. Community Service Work Hours, Part 8: Civil Actions, Sections 8-26 (regarding Guardians and Custody/Placement)
- Western Oregon Service Unit, Local Child Protection Team Policy

III. Tribal Profile

The Warm Springs Reservation was formed by The Treaty of 1855 and became the home to Wascos and Sahaptin speaking bands of the Upper and Lower Deschutes. At a later period, Paiute prisoners of war and their families were forcibly moved by the military to the Warm Springs Reservation. The reservation is currently home to the Warm Springs, Wasco, and Paiute Tribes. They are collectively referred to as the Confederated Tribes of Warm Springs, and are commonly referred to as the "Warm Springs Tribe."

Located in north central Oregon, the reservation covers an area of over 600,000 acres bound on the east by the Deschutes River and on the west by the Cascade Mountains. Figure 1 presents a map of the reservation.

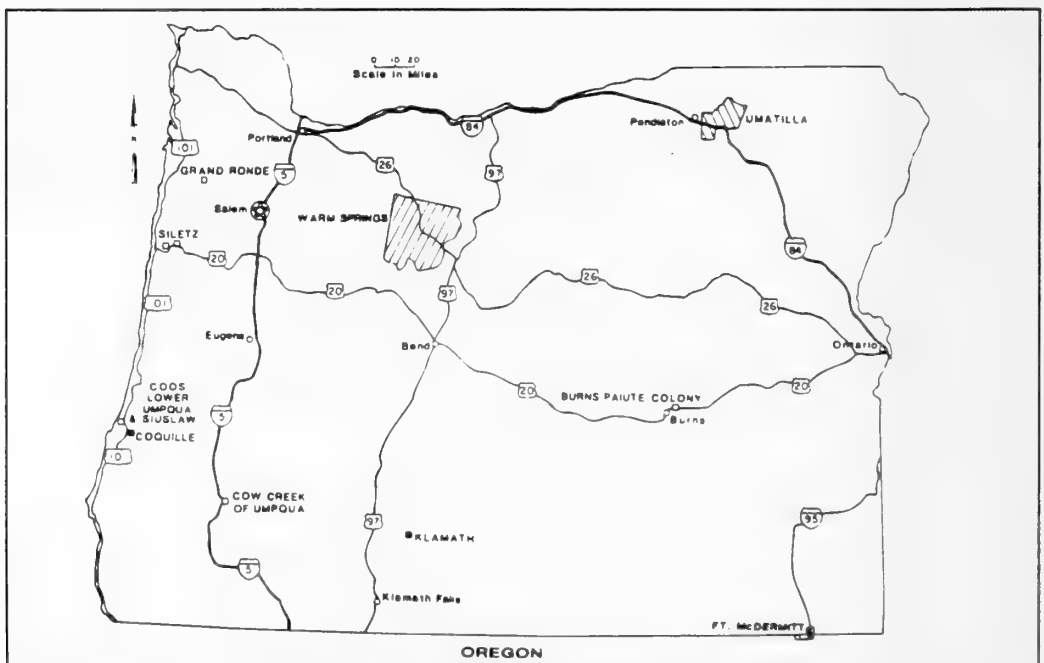


Figure 1. Location of the Warm Springs Reservation

There are 3,384 individuals enrolled in the Warm Springs Tribe, most (approximately 80-85%) of whom live on the reservation. Both membership requirements and economic incentives encourage members to reside on the reservation.

The Warm Springs Tribe has always been economically self-sufficient. Compared to the rampant unemployment that many tribes experience, the unemployment rate at Warm Springs is only about 14 percent. The Tribe presently operates many enterprises and governmental services employing in excess of 1,200 people. They have several industries including the logging and forestry products industry, Kah-Nee-Ta Resort (an exclusive tourist resort), and a hydroelectric plant. The tribe issues per capita payments monthly to each of its members, plus a bonus check at Christmas. Children under the age of 18 are given \$75 a month allowance, and the balance is put into an Individual Indian Money (IIM) account which they receive when they reach 18 years of age. These measures are strong economic incentives for members to remain on the reservation.

A. Government

In 1938, the Warm Springs Reservation was politically organized and chartered under the Indian Reorganization Act of 1934. The Tribes operate under a constitution and corporate charter, adopted by the membership at that time, which vests broad governing powers with the Tribal Council. The Tribal Council consists of eight elected members; the three chiefs are elected for life (one from each of the three districts), and the remaining eight council members are elected by popular vote from the three districts (3 from Agency, 3 from Simnasho, and 2 from Seeksequa). The Tribal Council appoints a Chairman, Vice-Chairman, and Second Vice-Chairman. The Tribal Council also appoints a Chief Executive Officer who is responsible for the daily operation of the Confederated Tribes.

The Tribal Council holds a special election approximately every 5 years to vote in adopted members. To be adopted by the Tribe, a person must be on the ballot when at least 50 percent of the eligible voters vote. If less than 50 percent of the eligible voters vote, the election is considered invalid. A person may re-apply and have his name added to the ballot for the next special election. The Warm Springs Tribe currently maintains an "adoption pool" of about 105 people. The last special election was in 1987; at that time 78 names were on the ballot. The election was declared valid, and 20 individuals were adopted into the Tribe. Adopted members are eligible for all benefits and privileges provided to other tribal members.

The Warm Springs Tribe has a well-developed governmental structure; each division of the government has clearly defined roles and responsibilities. The health service delivery area (HSDA) and the contract health service delivery area (CHSDA) are the same and include the reservation and the five adjacent counties of Wasco, Jefferson, Deschutes, Clackamas, and Marion. Figure 2 presents an organizational chart for the Tribe.

Warm Springs Tribal Organizational Structure

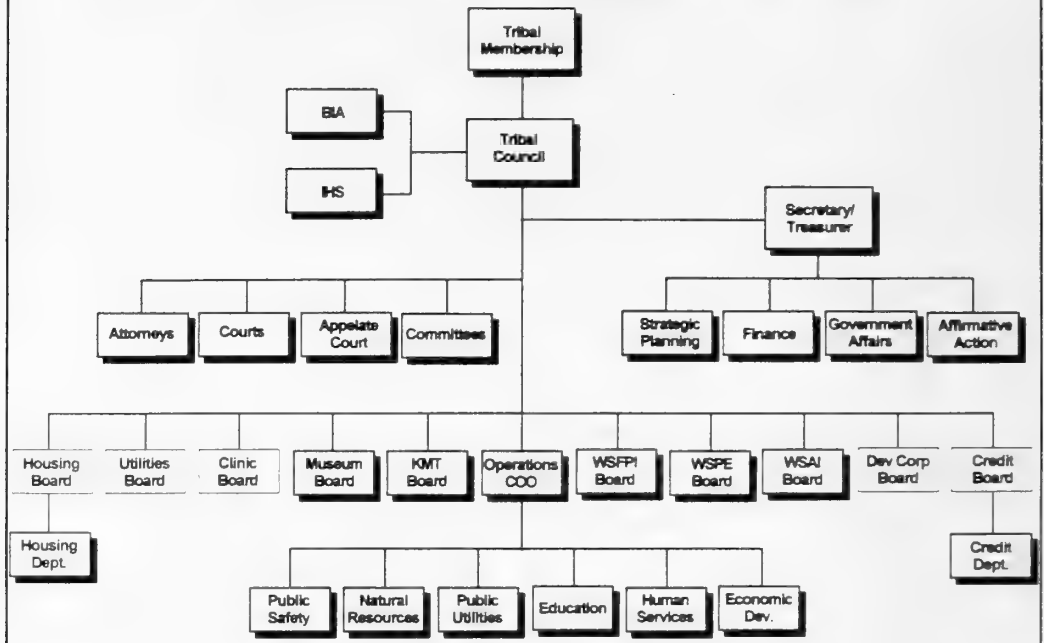


Figure 2. Warm Springs Tribal Organizational Structure

B. Judicial System

There are three tribal judges and one separate juvenile court. The Chief Judge usually handles the juvenile and domestic case, and the two Associate Judges handle other cases. Judges are appointed by the Tribal Council and serve 4-year terms. There is also a public defenders office; however, clients have the option of seeking outside representation. In tribal court, clients do not have to be represented by an attorney; however, there are restrictions on qualifications for representation including the admission to practice by the authority of the Chief Judge. Court is held on a daily basis; jury trials are held on Tuesdays and Thursdays.

It was estimated that there is an average of 6,000-7,000 cases per year, about 3,200 are related to family violence, and there are many repeat offenders.

The following information summarizes the laws governing family violence and related offenses to the Warm Springs Reservation.

The Family Abuse Prevention Law: This Law (Resolution No. 7868) was passed on August 1989 in order to resolve some of the difficulties encountered by victims of family violence in seeking a temporary restraining order or an injunction against a family or household member. The previous Tribal Code offered only a criminal proceeding or divorce petition. Lack of viable alternatives jeopardized the victim's safety.

Under the Family Abuse Prevention Law, victims of family violence may seek relief through the Tribal Court by filing a petition for a temporary restraining order or an injunction. In addition, the Court can approve any consent agreement to stop the abuse and has the right to award temporary custody or visitation rights when necessary.

Juveniles: Resolution No. 7857 is an amendment to the provisions of Chapter 360 of the Warm Springs Tribal Code dealing with juveniles. This resolution was passed in July 1989 in an effort to enable the Juvenile Court to better serve the needs of juveniles. Under this Resolution, Juvenile Court is granted jurisdiction "in any case involving a juvenile who is or is alleged to be a delinquent juvenile, or who is the subject of a petition for emancipation..." This Resolution also sets the guidelines for the appointments and duties of the Juvenile Coordinator/Presenting Officer.

Conservators and Guardians: Resolution No. 7117 was passed on March 31, 1986. Prior to the this Resolution, there was no provision in the Tribal Code regulating the appointment of conservators and guardians on the reservation. This Resolution entitles a family member of the ward and the Superintendent of the BIA (or the Superintendent's designee) to file a petition for the appointment of a conservator and/or guardian. Under this Resolution, the court may also issue an emergency order appointing a conservator and/or guardian pending a formal hearing, when such a measure is necessary for the protection of the ward or the ward's property.

C. Law Enforcement

The Warm Springs Law Enforcement Division currently employs 9 full-time officers (2 are contracted), 1 sergeant, and 1 captain. There are six criminal investigators (two are contracted through the P.L. 93-638 with the BIA). All officers handle felonies as well as negligent wounding and assault cases.

The police officers are responsible for Wasco, State, and Jefferson counties. The law enforcement division works closely with the tribal prosecutors office as well. The law enforcement division currently follows the protocol adopted in the Child Abuse Manual. Family violence is not specifically covered under tribal ordinance or legislation with the exception of the Family Abuse

Prevention Law; however, rape, assault, and battery are treated as felonies, thus applicable Federal law is used. The police officers receive 320 hours of training from the Oregon Police Academy (a certified state program) which includes 1) juvenile law, 2) child abuse, and 3) investigative procedures. Additional training is provided through the Indian police academy and other sources.

Juvenile Coordinators: Warm Springs employs two Juvenile Coordinators who work in the area of prevention of neglect and abuse. The Juvenile Coordinators work closely with the Police Department as well as the Victims Assistance Program. The majority of referrals are from the tribal court, although some are made by the Child Protection Services (CPS) and probation as well. Parents are often called in when a referral is received for a child; however, more often, direct contact is made with juveniles and parents which seems to be more effective. The coordinators stated they have worked with over 170 families and that the rate of success is very good. They indicated that many of the problems experienced by juveniles are a result of unresolved intergenerational issues in families causing mental anguish and abuse. The Juvenile Coordinators have developed a program tool called an "Inheritance Scale" to address patterns of abuse within each family. The scale is formalized with each juvenile and family to track their history and help recognize problems. The Juvenile Coordinators stated that the problems with youth appear to be increasing in grade school as well as high school. There is a problem with gangs; however, this problem is generally denied by parents and the community at large. In addition, easy access to alcohol and drugs contributes to youth problems. The coordinators felt that having a good role model is a big factor in addressing violence among the youth and adolescents.

D. Social Services

Community Counseling is a tribally-operated program contracted under P.L. 93-638 with a mix of tribal, state, and IHS alcohol and substance abuse funding. Community Counseling offers mental health services, substance abuse counseling, and referrals. Staff provide inpatient, outpatient, and emergency services. Community Counseling also provides services to victims and to court ordered referrals. Residential treatment is available for additional costs. Community Counseling contracts with three health care providers in Portland and Eugene, Oregon. A psychiatrist comes to Warm Springs to work on-site twice a month.

The Job-Training Partnership Program offers pre-employment and employment counseling as well as employment opportunities to community residents. Both the Program Coordinator and Assistant are volunteers with the Victims Assistance Program as well. The employment program provides clients with skill assessments, education, and career counseling. They provide referral, case management, job performance appraisals, evaluation, and follow-up for all clients and

potential/current employers. Assistance is provided for those individuals who wish to obtain GEDs. In addition, the program works closely with probation officers in coordinating community service work for offenders placed on probation. This program is closely linked to the community in addressing problems with the economy, homelessness, education, and other factors related to family violence.

The General Assistance Program provides financial support for food, clothing, and shelter for residents and their families. Eligibility for this program is based on income level, education, and other factors relating to employability. Referrals are received from the Victims Assistance Program as well as other tribal, Health and Human Services programs.

Figures 3-7 illustrate recent trends in family violence based on statistics provided by the Victim's Assistance Program.

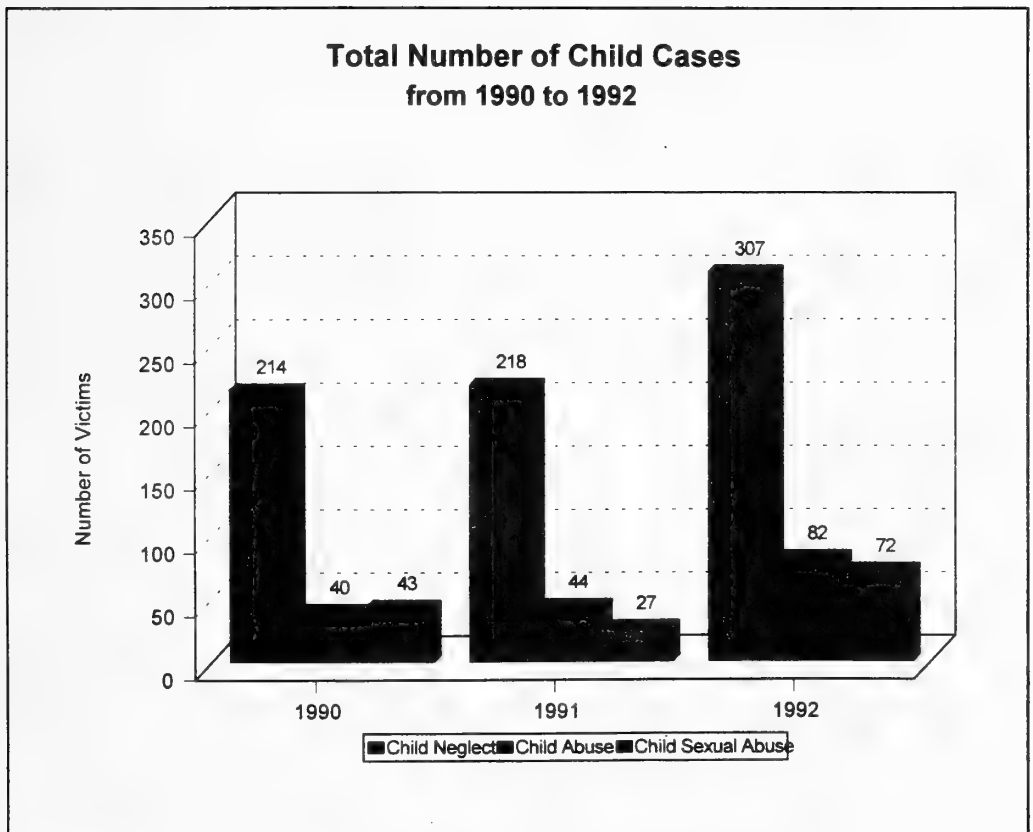


Figure 3. Numbers of Cases of Child Neglect, Abuse, and Child Sexual Abuse

Figure 3 shows that, over time, neglect and abuse cases are increasing at an alarming rate, ranging from 30-60 percent, from 1991-1992. Also, child neglect cases are 4-8 times more prevalent than child abuse or child sexual abuse cases.

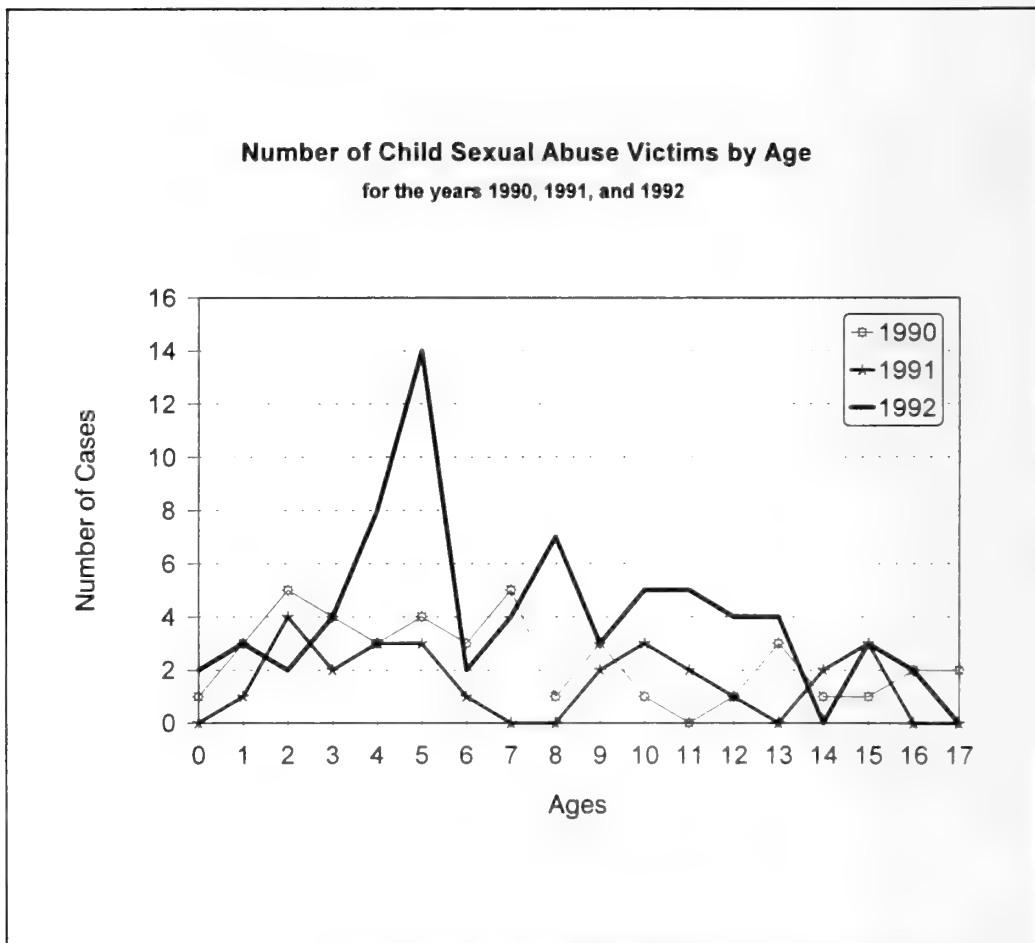


Figure 4. Child Sexual Abuse Victims by Age

Figure 4 shows that, across most age groups, child sexual abuse was greatest in 1992. Also the most vulnerable age group are 4-5 year olds and 7-8 year olds.

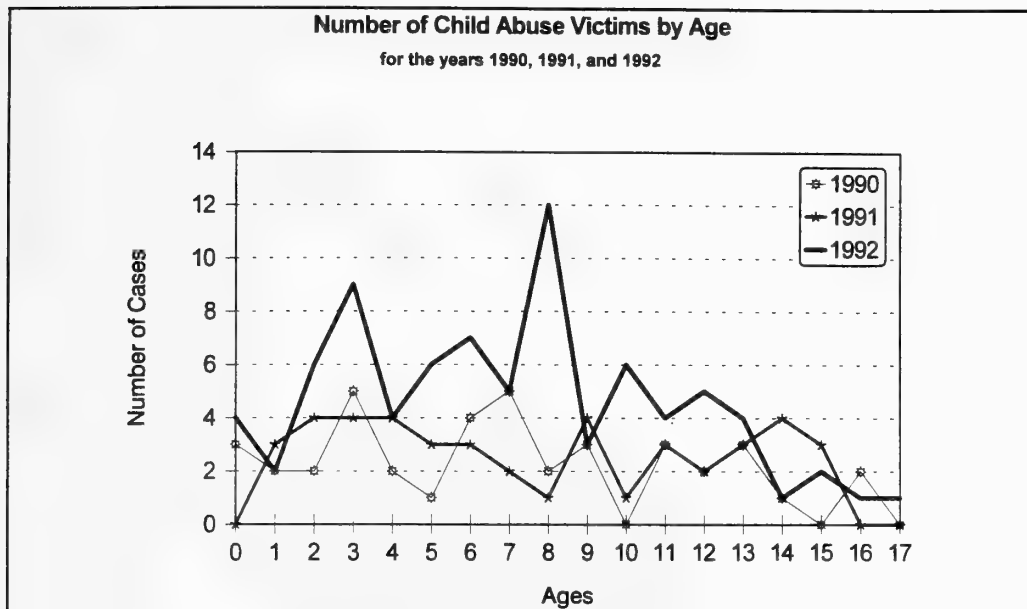


Figure 5. Child Abuse Victims by Age

Figure 5 shows that across most age groups, child abuse (like child sexual abuse) was greatest in 1992. Also, the most vulnerable ages for child abuse are 2-3, 5-6, and 8 year olds.

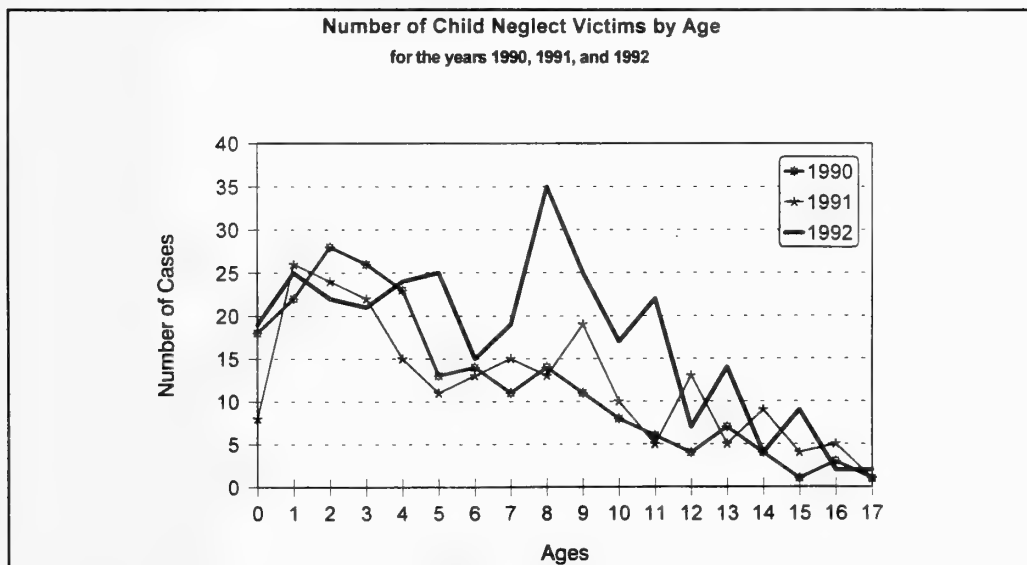


Figure 6. Child Neglect Victims by Age

As with the other figures, Figure 6 shows that across most age groups, child neglect was greater in 1992 than the prior 2 years. The most vulnerable age groups for neglect seem to be 2-4 and 7-9 year olds.

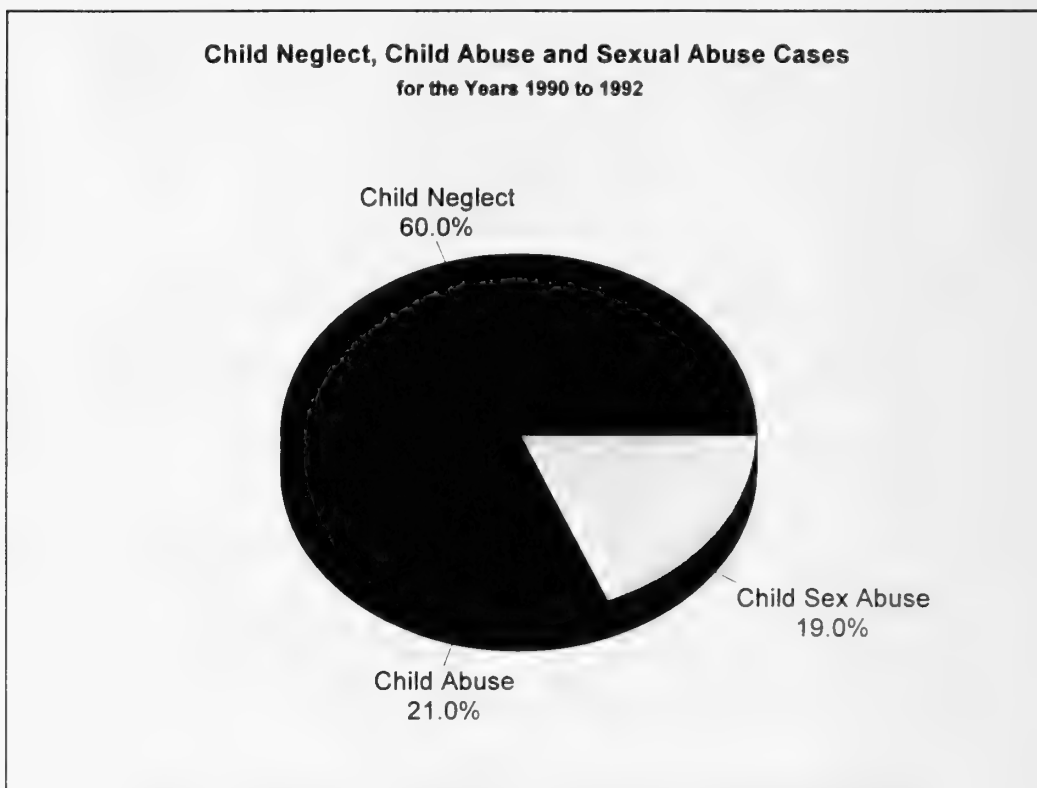


Figure 7. Distribution of Child Neglect, Child Abuse, and Child Sexual Abuse

E. Health Services

In 1988, the Confederated Tribes of Warm Springs began a strategic planning effort to improve the health of the Warm Springs community. This effort was carried out with the support of an IHS Management Grant. Through this grant, the Tribe developed a "health status information profile" which provided three categories of information 1) the current health status of the Warm Springs community, 2) present resource investments in Warm Springs health services, and 3) present efforts to plan for and promote improved health in the community. In addition, the tribe established a goal of becoming the healthiest Indian community by the year 2000. This goal includes not only the

absence of disease, but improvement of living conditions, promotion of healthy, well-adjusted individuals and families, and improvement of the quality of life for the community.

The Warm Springs Tribe has been providing a wide-range of health and social services since the late 1960s and early 1970s. The Tribal Health Department currently administers the following programs under a 638 contract: Alcohol and Drug, Mental Health, Health Education, Environmental Health, Maternal & Child Health, and Community Health Representative (CHR). In addition, the Tribal Health and Social Services Department receives several state contracts all of which are in compliance and are certified as providing quality service.

The IHS provides approximately 60 percent of the funding for the health care services provided to the Warm Springs Tribe. The tribe has devoted a significant portion of its own resources to the health care effort. Over 30 percent of the health resources of the community come from tribal funding. Of this amount, approximately 9 percent is through insurance for tribal employees, and an additional 21 percent is through direct funding by the tribe. The tribe is gradually moving in the direction that will permit development of its capacity and capability to address the larger and broader spectrum of health care. Twelve percent of the tribe's health care budget comes from programs such as Medicaid and Medicare, state programs, and other third party sources.

The tribe has constructed a new 37,000 square foot health facility. The plan is to lease the facility at no cost to the IHS under terms of Public Law 101-512 as a Joint Venture Demonstration Project. There are currently no IHS hospitals available to the Warm Springs Tribe; IHS health care is provided through contract health services. The clinic currently has two full time and four part-time physicians including one pediatrician, one optometrist, and an ear, nose, and throat specialist.

Health Education is a relatively new program. There are three health educators who provide information on HIV-AIDS education, self-esteem, spirituality, and child abuse and neglect. They use a community approach through three components: 1) discussion, 2) input from community, and 3) community ownership. To date information on family violence has not been presented. Presentations are made by the health educators to the Tribal Council, schools, and other groups.

A Community Field Health Nurse (CHN) works with the clinic in conducting home visits. The CHN receives referrals from the Senior Center, clinic, Maternal Child Health (MCH), pediatrician, and the early childhood program. The CHN is responsible for providing home assessments, and makes recommendations on public facilities. The CHN provides care, health education, and counselling for STDs, well baby care, and birth control.

The CHN is a member of the CPT. She also meets on a weekly basis with the senior advocates. There are periodic meetings with the nurse, physicians, and family members to resolve any family problems. The CHN often makes referrals to home health and the clinic for formal assessments or diabetic management. As a CHN, she is responsible for reporting all suspected cases of family violence to law enforcement; nevertheless, CHNs usually are not involved in spousal abuse. She stated there is no formal law about elder abuse unless the issue is monetary or neglect. It was also felt that 90 percent of all injuries treated are related to alcohol and drug abuse.

The Tribal Department of Health and Human Services also offers programs and services to youth and adolescents including a Girls and Boys Club, organized youth sports teams, school-based programs, Healthy Options for Teens, Futures of Children, Sports Camp, Wilderness Sports Camps, Student Youth Leadership, Student Trainee for College Bound, Conservation Corp, and the New Generation Dance Club. Other established programs include Head Start, WIC, Pre-School and Day Care.

F. Programs/Resources

Children's Protective Services (CPS) works with the courts and case management staff for any child who is at risk or is a victim of child abuse and neglect. Other services provided include foster and residential care (on and off the reservation), adolescent and foster homes for juveniles, and home evaluations. CPS works in coordination with the Family Preservation Program, the courts, and Victims Assistance Program.

The Victims Assistance Program (VAP) provides crisis intervention, emergency resources, and referrals to appropriate agencies and/or officials. Emergency requests for services can be made by contacting the Warm Springs Police Department. Often volunteers of this program accompany the police officers in responding to a situation involving domestic violence. The VAP is funded through the state Victims of Child Abuse Grants Program (VOCA), state of Oregon Department of Justice. These grants provide funding both for services to victims of violence and for the training and salaries of personnel working in the area of family violence. Transportation is provided to a shelter, a safe home, or relative, or to the hospital if medical attention is needed. In addition, VAP provides legal information and support for victims while they are working through the judicial system.

The VAP provides clients with information and referrals to other agencies including General Assistance, Children's Protective Service, Legal Aid, Community Counseling, Police Department, Tribal Social Services, IHS, and other adult and family services on the Warm Springs Reservation.

VAP works with victims of family violence to promote a safer environment for the family, and devises preventive measures against future incidence of violence. It addresses the psychological ramifications of family violence by helping victims cope with the situation, and providing necessary guidance in the healing process. The program also assists victims in identifying their legal alternatives, and provides relevant educational materials and referrals for further assistance. Rape/sexual assault victims are provided counseling, medical assistance, transportation, and legal advice. Child abuse victims and their families are provided a safe place and provided assistance to alleviate some of the psychological and social stigma of being a victim.

The Family Preservation Program provides family counseling services and differs from the Community Counseling in that programs can be tailored to meet individual needs. The family participates in setting up objectives and treatment plans through a discussion-type setting. The Family Preservation Program is funded through the National Center for Child Abuse and Neglect, Department of Health and Human Services.

IV. Findings

Informants were asked for their perceptions about violence in general and family violence in their community. Although the numbers of informants are small (37) and may not reflect statistically reliable data, their judgments provide valuable qualitative assessments for this study.

A. Prevalence of Violence

The majority of informants indicated that general violence and family violence are judged to be big problems with roughly the same magnitude in the Warm Springs Reservation (see Figure 8).

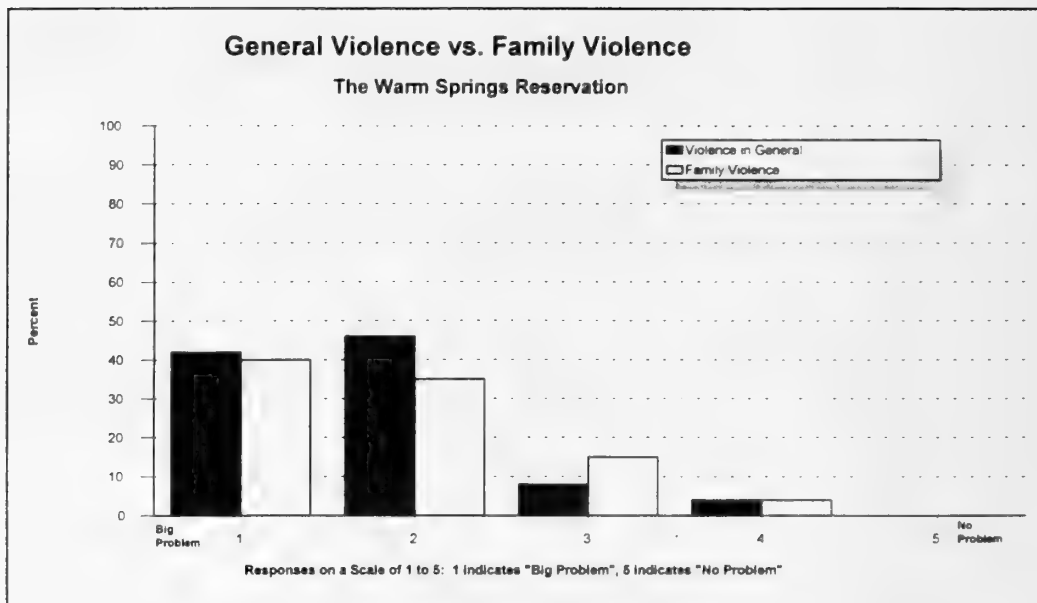


Figure 8. General Violence vs. Family Violence

Assessing the specific types of family violence, the majority of the informants indicated that both wife abuse, and child sexual abuse were big problems, followed closely by child abuse. Elder abuse was also cited as a problem although comparatively, on a smaller scale (see Figure 9).

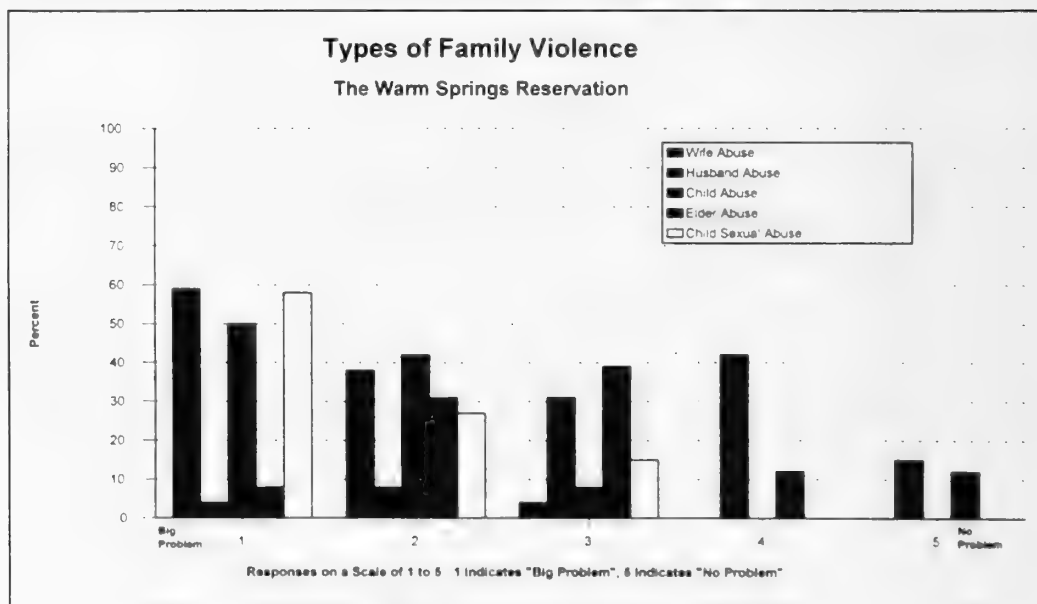


Figure 9. Types of Family Violence

About half of the informants indicated that physical assault without a weapon was a big problem, followed by rape and suicide (see Figure 10).

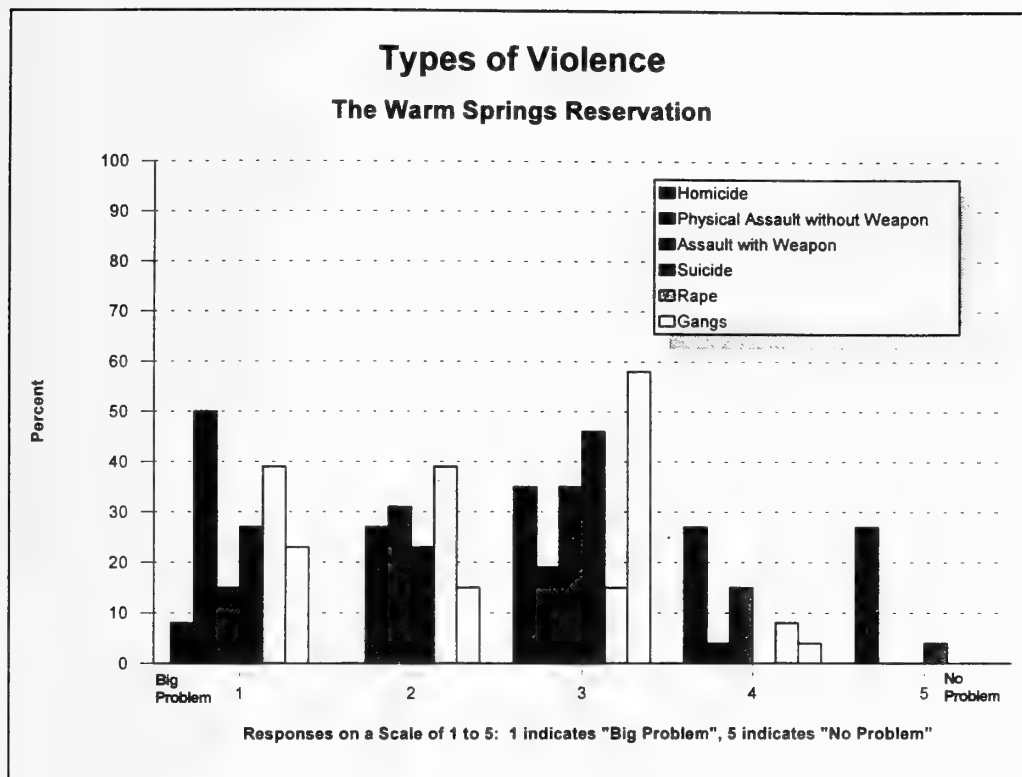


Figure 10. Types of Violence

The majority of informants believe that alcohol is almost always a factor in family violence and other types of violence.

More than half of the informants felt that most of the community was aware of the problem of family violence, and these informants indicated that the community's concern was appropriate to the scope of the problem.

B. Programs/Services

The informants indicated that the resources available to the community for family violence were average to excellent, and that access to the resources is average. Informants stated that the Victims Assistance Program was the most frequently used program, followed by the Family Preservation

Program, and Community Counseling. These programs provide services in anger management, alcohol and drug treatment, parenting classes, support groups, family counseling and individual counseling. Some informants indicated that family violence was being addressed by the courts through restitution, supervised probation, temporary incarceration, vigorous prosecution of offenders, and the implementation of the Family Abuse Prevention Law.

Table 1. Availability and Accessibility of Resources for Victims of Domestic Violence

	1	2	3	4	5	N/R
Availability*	8%	31%	39%	15%	8%	0%
Accessibility**	19%	31%	31%	15%	0%	4%
* 1=Excellent, 5=Non-existent ** 1=Easy Access, 5=No Access						

The majority of informants stated they dealt with family violence while on the job, primarily in positions associated with law enforcement and the courts, and involvement in conducting investigations (e.g., defenders, investigators, prosecutors, volunteers, and members of the Child Protection Team). Others stated that they dealt with victims as clients, employees and their children, as well as serving as a firefighter and EMT.

1. Programs/Services in Operation

Women's support groups, the Victim's Assistance Program and Community Counseling were the most frequently cited resources for victims of violence. Several others indicated anger management, Al-Anon, and impact panels were also available.

A list of a statewide network of resources for battered women is available through the Victims Assistance Program. These shelters include Central Oregon Battered and Rape Alliance (COBRA) in Bend, Oregon; Lincoln Shelter in Lincoln City, Women's Crisis Services in North Bend; and Domestic Violence Services in Pendleton, Oregon. Some individuals indicated that they did not know where shelters were located; others indicated that there were 1-5 shelters available. Most informants did not know how effective the shelters were.

2. Additional Programs/Services Needed

Most of the individuals felt that further efforts are needed to prevent family violence on the reservation. Current efforts were rated as relatively unsuccessful.

Table 2. Efforts to Prevent Family Violence on the Reservation

	1	2	3	4	5	N/R
Needed*	73%	27%	0%	0%	0%	0%
Successful**	0%	8%	19%	50%	15%	8%
* 1=Needed, 5=Not Needed ** 1=Very Successful, 5=Unsuccessful						

One informant indicated that although the shelters often accept individuals with children, the victim is so traumatized that it is difficult to assume responsibility for her children and to provide for their needs. In addition, leaving the reservation or being placed in shelters outside of the reservation results in cultural isolation. Placement of the victim outside the reservation may also remove her from supportive family members. Consequently, such victims often return to the reservation and to the abusive home situation as well.

C. Reporting

All medical, law enforcement, health and human services, and court personnel responded that they report suspected cases of abuse and neglect as required by law. The majority of abuse cases were reported to the police; child protective services is the second most commonly used choice for reporting cases of abuse. Other respondents indicated that they reported to community counseling, juvenile coordinators, and the Victims Assistance Program.

D. Coordination of Services

Informants indicated that client confidentiality issues sometimes keep counseling programs (Community Counseling) from providing necessary information to the courts. Informants reported the court can, and does, order counseling programs to submit reports. Failure to comply with the order can result in contempt of court. A pre-sentence investigation can be conducted with a request that an assessment be completed; however, this procedure is not always followed.

On the other hand, informants from the counseling programs reported that it is difficult to maintain client confidentiality. They felt that the courts mandate reporting without concern about the efficacy of treatment. Furthermore, the sentence imposed by the court does not really provide the offender with adequate treatment, so the cycle of violence continues. The offender usually ends up back in

the courts. It was also stated that sentencing is still based on old values of "punishing" without consideration for rehabilitation or treatment of the offender.

E. Training

Most informants indicated that they had received training through workshops and conferences addressing substance abuse, sexual abuse, and family issues. Many informants involved in social services, law enforcement, mental health, child abuse investigation, and family law training fields participated in state and national conferences sponsored by the National Indian Justice Center, (COBRA), and Seattle Indian Health Board (SIHB).

F. Difficulties in the Court System

Informants indicated that police officers are usually the first on the scene and have first contact with the victim. The police need to be sensitized and educated on how to deal with family violence. It was stated that 21 out of 100 reported cases were related to sexual abuse and oftentimes less than a fourth of these are investigated.

Staff from service programs need to be sensitized to the issue of abuse. For example, the Victim's Assistance Program is located near the prosecutors office; thus, often the victim is intimidated by the possibility of a chance encounter with her abuser.

Informants stated that the community oftentimes feels "picked on by the system," and treatment is often refused by the abuser and/or the victim. Denial is common among adolescents and adults. Some informants stated that the refusal of the Tribal Council to address the problem of family violence constitutes a form of denial. It was said that "politics prevent perpetrators from being prosecuted."

V. Recommendations

A. Education/Training

In-Service Training for Police. Police officers need to be sensitized and trained to deal with family violence. Local law enforcement officers who respond to family violence are usually concerned with immediately diffusing the situation by separating the parties and or by arrests (if alcohol and or

drugs are involved). Emergency calls for assistance from repeat offenders/victims of spousal abuse may be prejudged as non-emergency or perceived as an unnecessary problem in an already burdened work force. In addition, charges may be dropped during or after preventive efforts are underway through the courts. The police officer's approach to the situation should include a clear protocol that includes 1) protection of actual and potential victims, and 2) mandatory arrest for probable cause, ensuring that the victims are receiving support before leaving the scene.

Programs such as the Victim's Assistance Program, Community Counseling, CPT, etc., should make a concerted effort to ensure that the police department is included and represented in their work groups and other community efforts to address family violence. Open communication would help resolve misperceptions, as well as provide valuable information. Police investigations of family violence were reported as often unsuccessful in Warm Springs (only one fourth of the cases reported actually get investigated) and there is no follow-up by law enforcement or the court. Since police officers are the first to respond, the information obtained during the initial contact is critical. Other divisions such as criminal investigation, prosecution, and juvenile divisions rely heavily upon the police officer's judgement, report, and assessment of the case. The police department should be viewed as a valuable community resource and not as an obstacle.

The IHS should provide training for physicians on identification of family violence and on responding to subpoenas issued by the federal, tribal, and county courts. Cases oftentimes get dismissed because doctors are not willing to testify as key witnesses in abuse cases, citing the patient/doctor relationship as a cause.

In the case of child sexual abuse, evidence is often limited, and it is hard to gain medical examinations off the reservation. There are numerous critical time factors involved that often result in cases being dismissed. The tribe does not have access to physicians who specialize in conducting examinations of abuse victims. The IHS should offer specialized training to IHS physicians or at least have one physician in each area/facility who is experienced and prepared to handle such cases.

Workshops, seminars, and conferences are effective avenues for community education. When possible, elders should participate as trainers/teachers as they are a valuable resource, especially in utilizing spiritual approaches. Training should include methods of empowering individuals by dealing with those issues related to family violence.

School-based programs for early intervention/prevention efforts are needed. These efforts should be offered through Head Start, WIC, Pre-School, and Day Care. The importance of working with youth was stressed with an emphasis on individuals assuming more responsibility and accountability

for their actions. Determining the patterns of violence and how parents play a role in their children's lives is important in establishing intervention/preventive measures in early childhood. Ideas and beliefs need to be changed starting with children, and they must be taught positive ways of communicating.

Community outreach is needed through frequent communication through public service announcements, wellness and prevention programs, family and community functions, education, and participation of immediate and extended family intervention and prevention programs.

All agencies, organizations, programs, and individuals involved in family violence issues need to coordinate and network. With limited funding and resources, networking can reduce duplication of effort, and help programs function more efficiently. Tribal leaders must be more active in campaigning against family violence. One program recommends implementing a family mentor program to teach families how to communicate.

Substance abuse was most frequently cited as one of the primary factors related to family violence. Informants felt that programs addressing alcohol/drug abuse and the effect on domestic violence should be developed on the reservation.

B. Modify Judicial Services

More options for sentencing are needed with treatment and rehabilitation provided for perpetrators. The Tribe should implement harsher penalties on repeat offenders. It was cited that sentencing is still based on old values of punishment by incarceration. A judicial team has to be established for the court system to adequately address family violence. This team will coordinate resources and develop intervention/prevention plans for perpetrators and victims. The protocol to be followed by the team should include mandatory arrest of the abuser for probable cause, prosecution without need of formal complaint by the victims, court-ordered treatment with regular progress reports to the court, incarceration for failure of offender to complete treatment, and post-treatment follow-up. In addition, it was felt that a procedure for anonymous reporting should be provided.

C. Coordination of Services

It is critical that the Community Counseling and other programs provide information needed by the courts in handing out a fair sentence. Usually courts obtain reports from Community Counseling through probation officers; however, an official disclosure form releasing specific information must be signed and issued by the client. In addition, if the court does not receive the information in a

timely manner, cases will be dismissed. The court has indicated that information on the active attendance of the perpetrator, progress of the treatment, and recommendations from the counselor in regard to the offender are often lacking. A new set of protocols for Community Counseling, the court, the police and other organizations should correct these problems.

On the other hand, Community Counseling stated that nine times out of ten, court referrals for mandatory counseling are very vague with no written or set criteria. It is stated that sex offenders are often placed on probation for 6 months to a year, and referred to counseling; however, there is no stipulation or criteria on how to deal with the offender if the treatment is unsuccessful. Follow-up procedures must be set in place to monitor the perpetrator's progress and treatment by the courts in coordination with Community Counseling. The Tribal Code and associated judicial procedures should be amended to eliminate these problems.

Networking and coordination of all departments is required to ensure the victim's safety. Victims of child abuse and neglect are dependent upon the coordination of five or more departments including the police department, courts, child protective services, community counseling, and parole and probation.

D. Counseling

Greater responsiveness to clients who are desperately seeking Community Counseling services is needed. Often clients become disheartened after numerous attempts to obtain appointments from Community Counseling. Hotlines are needed so victims can reach help whenever necessary.

More case management and follow-up are needed. This follow-up should include the participant as well as other individuals directly involved including employers, supervisors, and counselors, etc.

Shelters and other programs off the reservation should be encouraged to employ or recruit volunteers from the reservation. Leaving the reservation or being placed in outside shelters is sometimes a problem because of cultural isolation and having to leave supportive family members. Often victims of family violence return to the reservation and end up returning to the abusive home situation as well. Victims of family violence should not be forced to leave their home and their homeland (i.e., reservation) to be free of violence and intimidation.

ATTACHMENT 2

EASTERN BAND OF CHEROKEE CASE STUDY REPORT

A CASE STUDY OF FAMILY VIOLENCE IN FOUR NATIVE AMERICAN COMMUNITIES

EASTERN BAND OF CHEROKEE

I. INTRODUCTION

Support Services International, Inc. (SSI) under contract with the Indian Health Service (IHS) conducted a case study on family violence on American Indian reservations. As part of the study, site visits were conducted to four geographically and culturally diverse Indian communities. The case study sites included the Rosebud Sioux Tribe, the Confederated Tribes of Warm Springs, the Navajo Nation, and the Eastern Band of Cherokee.

The purpose of the site visits was to collect primary and secondary data concerning 1) the prevalence of family violence, 2) the factors perceived to influence family violence, and 3) the intervention/prevention measures in place and/or under consideration. Secondary data were obtained from tribal programs, the IHS, the Bureau of Indian Affairs (BIA), state, and other programs.

This report is a summary of the site visit conducted at the Cherokee Reservation in North Carolina. It is important to note that while no single reservation or community is representative of any other, the results of this site visit should be of value as a case study of family violence in American Indian communities.

II. METHOD

The four case study sites were selected using the following criteria: 1) geographic and cultural diversity, 2) willingness of the tribe to participate in the study, and 3) availability of relevant data.

Once the tribes agreed to participate, a point of contact was established. Through a joint effort, a site visit protocol and itinerary were developed for on-site data collection.

Data were collected through 1) unstructured interviews with key informants including representatives from tribal, Federal, and state programs, and 2) review of secondary data sources. A discussion of each data source is presented below.

A. Unstructured Interviews of Key Informants

Representatives from tribal and other programs focusing on family violence (e.g., social services, mental health, law enforcement, judicial, medical, and the education system) were interviewed. Informal discussions were conducted with 31 key informants:

- Donna Arch, Magistrate
- Teresa Bryant, Maternal Child Health
- Dr. Paula Butler, Tribal Health Delivery
- Larry Callicutt, Tribal Administrator
- Debbie Chiltoskie, Juvenile Court Magistrate
- Dr. Jim Cox, Cherokee Tribal Behavioral Health
- Joletta Crowe, BIA Social Services
- Joe Davis, Acting Administrator, Cherokee Hospital
- Joyce Dugan, Cherokee School Superintendent
- Peggy Hill-Kerbow, Cherokee Children's Home
- Dianne Hyatt, CFR Clerk of Court
- Gil Jackson, Head Start Director
- Jerry Kinsland, Tribal Emergency Medical Services
- Kathi Smith Littlejohn, Director, Cherokee Senior Citizen Program
- Alfred Lossiah, Director, Chemical Dependency Unit (CDU)
- Scott McConnell, Police Officer
- Emma McMillan, Hope Center, Cherokee High School
- Jess Murphy, Tribal Council
- Wilbur Paul, BIA Superintendent
- John Quinette, Social Worker, Swain County
- Norman Reed, Police Office
- Regina Rosario, Tribal Investigator, Child Sexual Abuse Cases
- James Sanders, BIA Social Services
- Roseanna Sneed, Counselor, Cherokee Elementary School
- Ray Swayney, Police Chief
- Bill Taylor, Tribal Council
- Marion Teesateskie, Tribal Council, member of Child Protection Team

- Abe Wachacha, Tribal Council
- Arnold Wachacha, Tribal Council
- Amy Walker, BIA Social Services
- Ernestine Walkingstick, Director, Community Health Nursing

Discussion with key informants, ranging from 50 to 90 minutes, were conducted over a 3-day period in January 25-28, 1994. Each informant was interviewed separately by contractor (SSI) staff. After the interviews were completed, the interviewers prepared a summary of the information collected. During the exit interview, this summary was presented for feedback. Finally, the draft of this Case Study Report was submitted to the tribe for review and feedback. This document reflects the feedback obtained from the reviewers.

B. Sources of Secondary Data

The following documents were collected and reviewed:

- SAFE Shelter Policy Book, Swain/Qualla, SAFE, Inc.
- Domestic Violence and Rape Crisis Services, Swain/Qualla SAFE, Inc.
- Yearly Statistical Report, SAFE Inc.
- Enrollment Criteria, 25 CFR Chapter 1
- Demographic Data on Enrolled Members
- Annual Report, Criminal Investigations Divisions, FY 1991-1992
- Annual Report, Criminal Investigations Divisions, FY 1992-1993
- CPT Meeting, IHS, BIA
- Organizational Chart, Branch of CFR Court
- Jurisdictional Chart
- General Information, Branch of Social Services, BIA
- List of Applicable Codes, Criminal Investigations Division
- Overall Economic Development Plan
- Qualla Boundary Service Directory
- Domestic Violence Ordinance No. 97

III. TRIBAL PROFILE

The Eastern Band of Cherokee Indians known as Yun-wi-yuh, "Principal People" at one time inhabited over 55,000 square miles in Tennessee, Alabama, and Georgia, as well as portions of Kentucky, South Carolina, and North Carolina. In 1785, there were approximately 64 villages and towns. After adoption of the constitution, the Cherokees were not recognized as citizens of the United States; therefore, they could not hold title to the land. While there were many treaties between the United States and the Cherokees, most of the treaties were not upheld. With each broken treaty, the Cherokees lost more and more of their land. In 1883, General Winfield Scott was ordered by Congress to move the Cherokees to the west. This forced relocation, known as the "Trail of Tears," was made under military escort and many Cherokees died en route to Indian territory in Oklahoma. All present day Cherokees are descendants of one tribe. The descendants of those who survived the march to Oklahoma in the Trail of Tears constitute the Western Band of Cherokee, and the descendants of those who were left behind, refused to go, or returned, constitute the Eastern Band of Cherokee.

Shortly after the relocation of the Cherokees to the west, W.H. Thomas set out to purchase the Qualla Boundary, a large tract of land in western North Carolina. Well known and liked by the Cherokees, W.H. Thomas was adopted into the Tribe by Yonaguska, the Principal Chief's son, and was given the name "Will-Usdi." In 1938, Yonaguska died, and Usdi was elected to the position of Chief, the only non-Indian to hold an elected position in the Cherokee Tribe. Usdi acquired funds from the Indians as well as other sources and bought the land; the purchase was approved in 1866 by the U.S. Government. In the same year, the state of North Carolina recognized the Eastern Band of Cherokee, and in 1889, the North Carolina General Assembly granted a charter to the Cherokee.

During the years 1870-1890, the Cherokees were involved in several law suits pertaining to land titles. In 1890, an estimated 40,000 acres of the Qualla Boundary was sold for taxes; however, in 1892, Congress made an appropriation for redemption. In 1924, the title was conveyed to the United States for protection, and in July 1925, the land of the Eastern Band of Cherokee was placed in trust by the Federal government. Figure 1 shows the boundaries of the Cherokee Reservation.

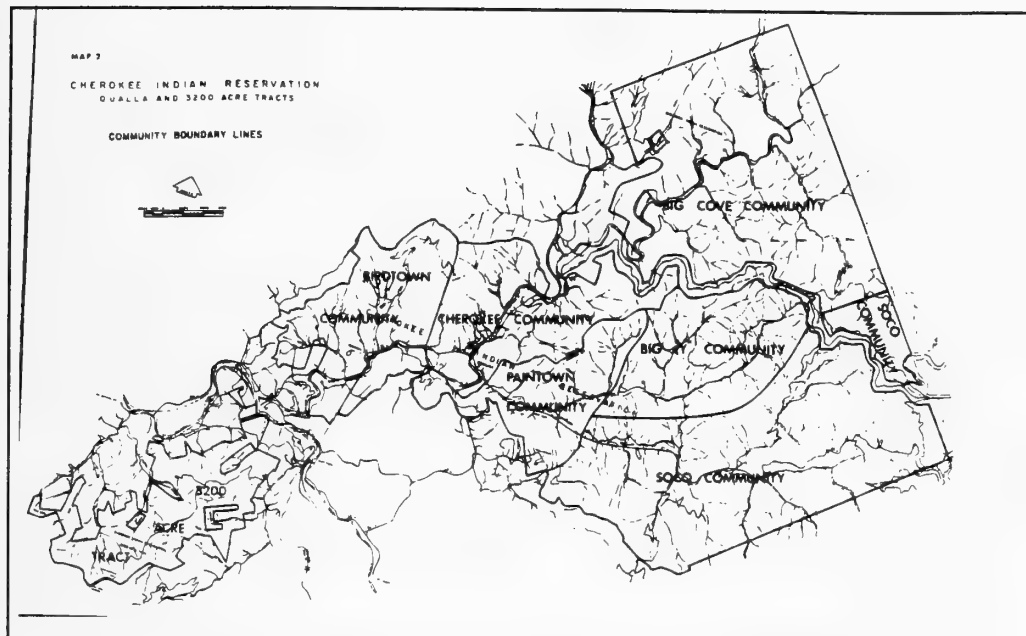


Figure 1. Boundaries of the Eastern Band of Cherokee Reservation

Although the language and other unique traditions still exist, (basketmaking, pottery, carvings, and weaving), the Cherokees have adapted many of the customs and living standards of their non-Indian neighbors. The Cherokee language is one of the few written Indian languages. Sequoyah, a noted Cherokee scholar, developed an alphabet. The Cherokees have seven clans: Long Hair, Wolf, Wild Potato (Bear or Raccoon), Blue (Panther or Wild Cat), Bird, Paint, and Deer.

There are currently 10,320 enrolled members of the Eastern Band of Cherokee; over 66 percent live on the reservation, the other 33 percent live off the reservation. The population estimates for the Eastern Band of Cherokee often include individuals in one of the following categories: 1) enrolled Eastern Cherokees, 2) enrolled Eastern Cherokees living on Eastern Cherokee tribally-owned lands, 3) enrolled Eastern Cherokees living on or near the Eastern Cherokee tribally-owned lands, 4) enrolled Indians, non-Cherokee, living on Eastern Cherokee tribally-owned lands (usually married to an enrolled Eastern Cherokee), and 5) non-Indians living on Eastern Cherokee tribally-owned land.

The economy of the Eastern Band of Cherokee is primarily supported by tourism and other commercial projects, light industry, and a variety of Federal and tribal activities. Most of the

employment is seasonal; during the summer months, many employment opportunities exist in the commercial sector including tourism and related recreational activities.

The Cherokee Reservation is endowed with important natural resources that serve both as a source of income and that enhance cultural values in the community. The tribal government is aware of the need to achieve a balance between the use of natural resources for economic development and the preservation of the natural environment for future generations.

More than 85 percent of the land belonging to the Eastern Band of Cherokee is covered by Southern Appalachian hardwood forest. The timber harvested from these forests constituted, at one time, the major source of income for the Cherokee people. In recent years, the average yield of timber harvest has been approximately 2,105,000 board feet per year with an estimated \$24,399 in stumpage income for both individual tribal members and the Eastern Band itself.

The Cherokee Reservation has a wide variety of religious organizations. The dominant religion is Christian and is represented by Baptist, Lutheran, Catholic, and Methodist denominations. There is no established Native American church. Because of systematic efforts to suppress traditional Cherokee language, customs, and religious practices, many traditional cultural practices have been lost or abandoned.

A. Government

The Eastern Band of Cherokee Indians is governed under the 1889 Cherokee Charter under the laws of the state of North Carolina. Under Section 1 of the Charter, the Eastern Band of Cherokee has all the rights, franchises, privileges, and powers granted corporations under the laws of the state of North Carolina. The Charter also establishes that the officers of the corporation shall consist of the Principal Chief, Vice-Chief, and 12 council members.

The Tribal Council is the governing body of the Cherokee Reservation and consists of twelve members who are elected for 2-year terms. The Tribal Council appoints a Chairman, Vice Chairman, Indian and English clerks, an interpreter, a marshall, a messenger, a janitor and administrative assistant. Section 22 of the Cherokee Charter, as amended, provides for the management and control of tribal lands and property by the Cherokee Tribal Council. The Tribal Council also serves as a legislative body and performs judicial type functions as well.

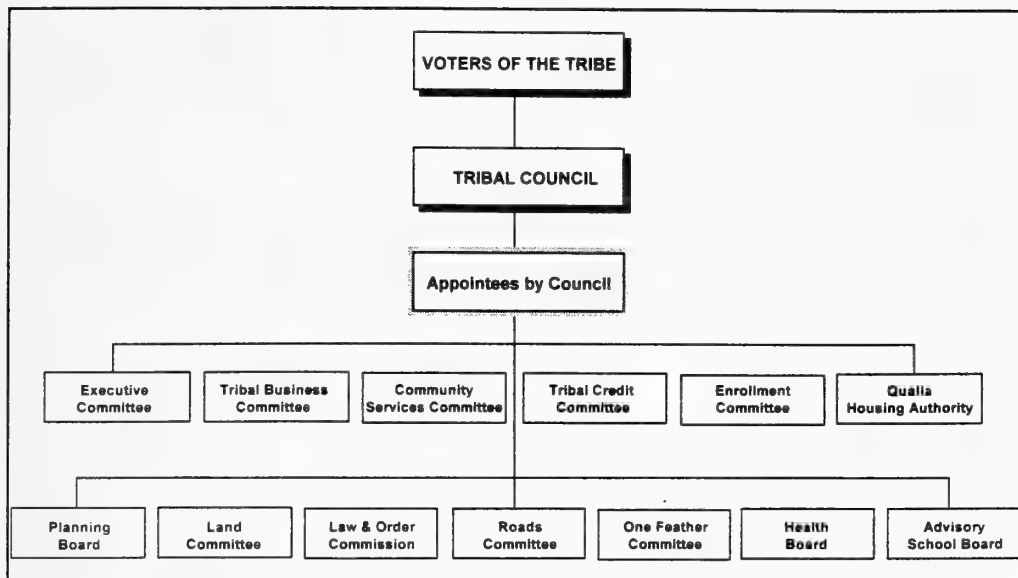


Figure 2. Tribal Organizational Chart of the Eastern Band of Cherokee

The Executive Committee consists of a Principal Chief, a Vice-Chief, and an Executive Advisor. The Principal Chief and Vice-Chief are elected for 4-year terms by the enrolled tribal members over the age of 18. The Executive Advisor is appointed by the Principal Chief and ratified by the Tribal Council. The Executive Department is under the direction of the Principal Chief and is responsible for the implementation of tribal rules, regulations, and administration (see Figure 2).

There is a unique relationship between the Tribe, the state of North Carolina, and the counties surrounding the Cherokee Reservation. Representatives from Swain and Jackson Counties Departments of Social Services have been provided office space at the BIA offices on the reservation. Some tribal members prefer using off-reservation county and state social and mental health services. The BIA Cherokee Indian Agency also provides numerous services on the reservation including adult education, the CFR court, credit and financing, employment assistance, forestry, realty, roads, and social services.

B. Judicial Services

The tribal court is a "CFR court" operated by the BIA; however, the Tribal Council assumes responsibility for appointing the Magistrates. There are four Magistrates appointed for four-year terms, and one Court Clerk, all confirmed by the Tribal Council. Newly appointed Magistrates are serving 2 year terms in anticipation of the Tribe assuming the operation of the court system. Under

consideration are adoption of a constitution, assuming control of the tribal courts, and the hiring of tribal social workers. The prosecuting attorney as well as the Public Defenders are non-Indian and are contracted by the court.

The court handles misdemeanor cases, civil cases, divorce, custody, and traffic offenses. Civil court is held once a week. The CFR court does not handle domestic violence cases or any other Federal offenses involving felonies. The state court has an agreement with the tribe to process dependency and custody cases which are coordinated through Social Services. Other Federal offenses are handled by the Federal courts in Asheville or Bryson City.

Informants indicated that residents had little confidence in the courts, because of confidentiality issues and other factors. They further indicated that women were more confident that they would be able to obtain help in domestic violence cases. It is often difficult for the Tribe to prosecute spouse abusers because the victims frequently refuse to cooperate with the prosecution despite having signed a complaint at the time of, or shortly after, an attack. The court has implemented a fee as an incentive for individuals to follow-through on spouse abuse cases. Each time the victim refuses to cooperate with prosecution of the abuser, this fee is increased. The courts will often refer any alcohol related offenses to the Clinical Dependency Unit for evaluation. In addition, clients are often referred to Social Services and counselors; written reports are often requested by the court. The Tribe contracts with Swain County for jail services.

The Juvenile Intake Program is tribally-operated. The majority of referrals are from the police department, although individual complaints can be processed by the Juvenile Intake Coordinator. There are currently two employees, one Coordinator and a juvenile police officer.

The Tribe passed a Domestic Violence Ordinance in February 1990 which specifies jurisdiction over all actions within the Court of Indian Offenses. The Ordinance includes bodily harm, protective orders, custody, and emergency assistance for residents within the boundaries of the reservation, and those married to or living with an enrolled tribal member.

C. Law Enforcement

The Police Department is funded and operated by the Tribe, and is responsible for the enforcement of all laws pertaining to the Cherokee Reservation and trust lands. There are a total of 20 police officers and two criminal investigators with the department. The police officers are federally deputized and are required to pass all training requirements of the state of North Carolina. The Tribal Council appoints the Police Chief and approves the hiring of police officers as well.

The Criminal Investigations Division is a P.L. 93-638 tribally-contracted program. The Division is responsible for investigating major crimes against the United States and for the arrest of persons suspected of committing such crimes. One of the two investigators handles the child sexual assault/abuse/neglect cases, and the other investigator handles crimes against people as well as crimes against property. There are 18 crimes mandated under the United States Codes of Federal Regulations. The primary source of referrals are Police Department, CFR court, and Division of Social Services.

D. Social Services

Social services are provided by the BIA, the IHS, and under contract with Swain and Jackson counties. State standards are used in determining need for social services; eligibility for these services is based on gross family income. Certain services are available to families with higher income levels. Applicants for these services must meet varied income/reserve guidelines in addition to specialized program requirements such as child deprivation in the Aid for Dependent Children (AFDC) programs, disability in aid to disabled Medicaid program, and household unit division in food stamps.

The BIA Department of Social Services receives referrals from the IHS Chemical Dependency Program, Aid for Families with Dependent Children, and the SAFE shelter. Assistance is provided to clients in determining eligibility and supporting documentation for program services. In addition, social workers provide information on protective services through Swain and Jackson counties and other sources for protective and advocacy services.

The BIA Social Services Director is responsible for directing the Child Protection Team (CPT). The Tribe has a Memorandum of Agreement, predating the Indian Child Welfare Act (ICWA), that mandates that counties deal directly with the Tribe. Procedures for dealing with family violence cases are somewhat abstract, and have evolved over a period of years. The CPT is a multi-disciplinary team which includes representatives from the Tribal, Federal, and state governments. There is a protocol outlining roles of each member. The state of North Carolina requires that each county have a CPT. Swain and Jackson County overlap the reservation boundaries; therefore, a social worker from each county is housed in the BIA offices. The BIA Social Service Director attends CPT meetings for both of these counties.

The CPT provides an array of services including child and adult protection, adoption, foster care for children and adults, community living, delinquency prevention, pregnancy counseling, health support services, and information and referral for Swain and Jackson counties.

The staff of the Chemical Dependency Unit (CDU), located in the Cherokee Indian Hospital, includes a Treatment Director, a Family Therapist, Certified Alcoholism Counselor, Clinical Psychologist, and a Mental Health Technician. Services include preventive education, outpatient counseling, Detox, 30-day adult male residential treatment aftercare, follow-up services, family therapy, and inpatient counseling. The CDU receives referrals from court, the hospital, SAFE, Inc., social services, and other agencies. The program admits referrals and clients from other federally-recognized reservations as well.

E. Health Care Services

The Cherokee Indian Hospital is operated by the IHS, and provides a variety of services to the members of the Cherokee Tribe. The hospital has a written protocol which mandates reporting of child and elder abuse in accordance with the North Carolina Criminal Code. In suspected cases of abuse (including frequent visits to the emergency room, discrepancies in clinical and historical client data, undisputed signs of neglect, unexplained injuries, etc.), the hospital social services, Swain or Jackson County Social Services, or the Cherokee Police Department is contacted.

Services provided by the hospital include the Chemical Dependency Unit, Community Health Nursing, Contract Health Services, dental clinic, ambulance service, emergency room services, health education, laboratory services, Medicaid and Medicare, medical social services, nutrition, environmental health, hearing clinic, pharmacy, physical therapy, and X-ray.

The Tribe operates an Emergency Medical Services (EMS) program. EMS staff who suspect abuse and/or neglect cases are required report to the proper authorities. There is an emergency dispatch number directly linked to the police department. The police officers will often secure the scene of an accident or offense prior to the arrival of EMS. A detailed report of the EMTs observations are recorded for each run. Referrals are made if a patient refuses medical services or emergency transport.

F. Education

Federal programs such as "Head Start" and "Follow Through" have made a significant impact on the education of Cherokee youth. Head Start staff makes referrals as needed to medical staff. Although the Tribe does have a "dropout" problem, the rate is lower than that of many other tribes. There is a shortage of college educated Cherokees which puts a burden on the Tribe to find qualified tribal people to replace non-Indians in positions of management, administration, and in the Judicial system.

An effort is underway to include Cherokee language and culture as part of the K-12 curriculum. While students have the option of attending off-reservation public schools, the vast majority of Indian students attend the Cherokee school system (an estimated 700 elementary and 300 middle and high school students). The Cherokee School competes with other public school systems in Swain and Jackson counties. The Tribe requires employees of the Cherokee School system to enroll their children there as well. Currently an estimated 400 Cherokee children attend other off-reservation public schools.

All suspected cases of child abuse or neglect are reported directly to the principal by any school official, faculty and counselors who, in turn, will contact Social Services. With physical abuse, the child will be examined by the school nurse, and within 24 hours, will be interviewed by Social Service staff. The school will report any visible sign of abuse on a child. After the case is reported, the school has no further role in the referral process. In addition to reporting cases of suspected child abuse and neglect, attendance is monitored and reported by school personnel.

G. Other Programs/Resources

Swain Qualla SAFE, Inc. is a private, non-profit shelter primarily available for residents of Swain County and the Cherokee Reservation. The shelter, located off the reservation, provides a variety of services including a temporary safe home (for up to 90 days), information about battering and abuse, legal information and referral, court advocacy, planning and options counseling, group support, limited child care, and transportation. The shelter is funded through the Family Violence Act, tribal, and state monies. Staff are available to attend court with clients as advocates.

SAFE, Inc. receives referrals from the tribal Police Department, churches, hospitals, social services, Magistrate, WIC, schools, and from the general public. The SAFE shelter is open 7 days a week, and staff are on call 24 hours a day. They often meet with victims in neutral locations and provide them with plans. Over half of the clients are from the Cherokee Reservation. The SAFE shelter is considered an important resource for the Cherokee. As shown in Figures 3 and 4, the shelter also serves the non-Indian population.

Total Number of Clients Sheltered at SAFE (1991-1992)

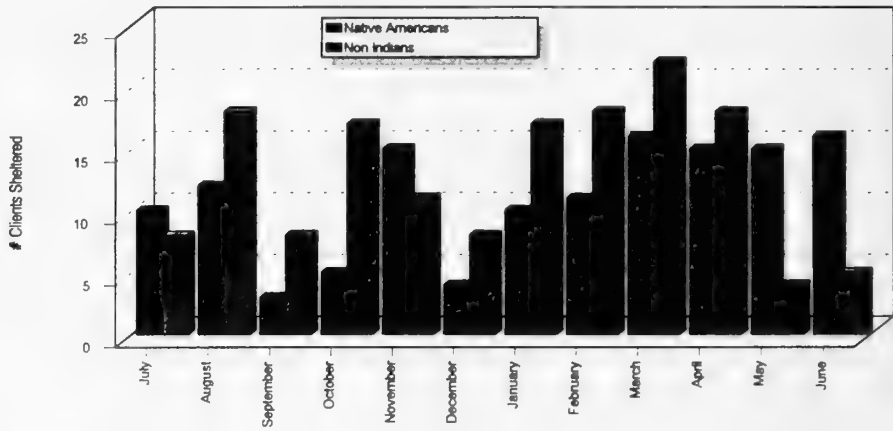


Figure 3. Total Number of Clients Sheltered (1991-1992)

Total Number of Clients Sheltered at SAFE (1992-1993)

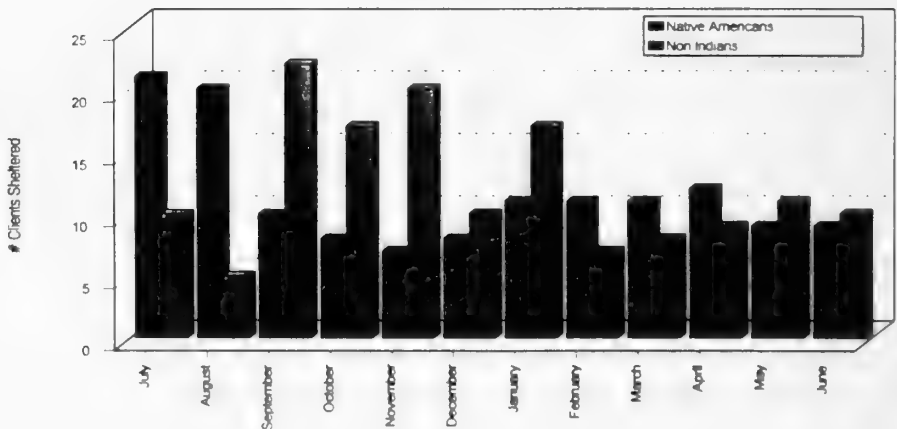


Figure 4. Total Number of Clients Sheltered (1992-1993)

In 1969, the Cherokee Children's Home was organized and built by the Cherokee Boy's Club. The home is now licensed to provide services to seven counties. The Children's Home is one of the eleven programs provided by the Cherokee Family Services. Other services include: 1) therapeutic outdoor activities, 2) Cherokee Challenge and Prevention Program (serving children 9-14), 3) outdoor adventure classes contracted with universities, 4) family services (referrals or voluntary), 5) food bank, 6) day care, 7) 24-hour shelter for children, 8) residential program, 9) out-of-home placement, 10) children's home, and 11) parenting program.

The Cherokee Center for Family Services (CCFS), a department of the Cherokee Boys' Club, is a non-profit organization which provides case work services to families. There are three residential cottages that are home to victims during their out-of-home placement. Each cottage is staffed by full- and part-time resident counselors. In 1993, services were provided to 22 enrolled members and to 15 non-tribal members. Ten referrals were for neglect, two for drug dependency, four were Federal cases of sexual abuse (3 convictions), 4 were referred from UNITY, a non-profit youth organization, and 3 were self-referrals. The CCFS receives referrals from the IHS and BIA Social Services divisions, county social services, courts, and UNITY. Families are required to meet the minimum state requirements to regain custody of their children once they are placed in the Children's Home. The Children's Home has a Memorandum of Agreement with the state court regarding placement and custody. The CCFS also recruits foster homes and provides training in Swain County.

There is a Volunteer Parenting Program available to all members of the reservation. It is a 8-10 week program open to students from ages 12-16 who are pregnant or who have children. The program has a support group that meets once a month. Swain County has the highest rate of teen pregnancy in the state. There is a Teen Center which offers health programs, peer group education, counselling, and group education. The Teen Center works directly with the school system.

The Smoky Mountain Center for Mental Health, Mental Retardation, and Substance Abuse Services serves both Swain and Jackson counties and Cherokee residents. The Center is located in Bryson City, North Carolina, and provides outpatient/inpatient services, partial hospitalization, emergency services, substance abuse counseling, child and youth programs, and mental health support services, and community education. Due to the off-reservation location and confidentiality issues, some patients from the Cherokee Reservation prefer this facility over the Cherokee Indian Hospital.

IV. FINDINGS

Informants were asked for their perceptions of the problem of general violence and family violence in their community. Although, the number of informants, (31), is small and may not reflect statistically reliable data, the statistics reported in this section represent valuable qualitative assessments for this study.

A. Prevalence of Violence

As shown in Figure 5, informants indicated that general violence and family violence are somewhat of a problem in the Cherokee Reservation.

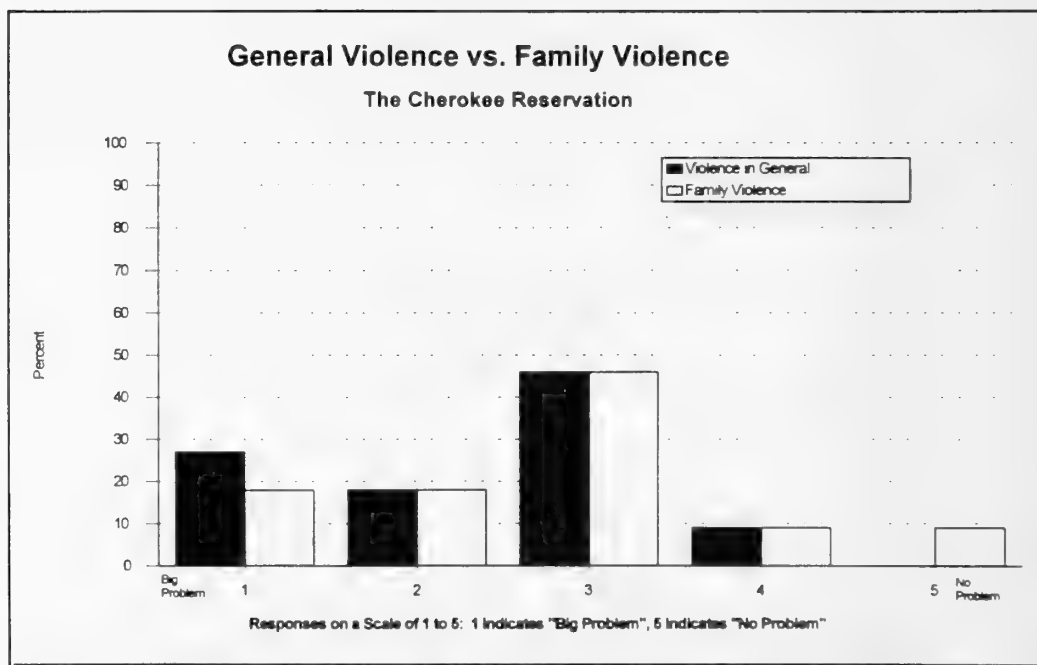


Figure 5. General Violence vs. Family Violence (Cherokee)

Informants reported that the most common types of family violence were wife abuse, followed by child sexual abuse, and child abuse (see Figure 6). Elder abuse was reported to be somewhat of a problem, but less than the other categories.

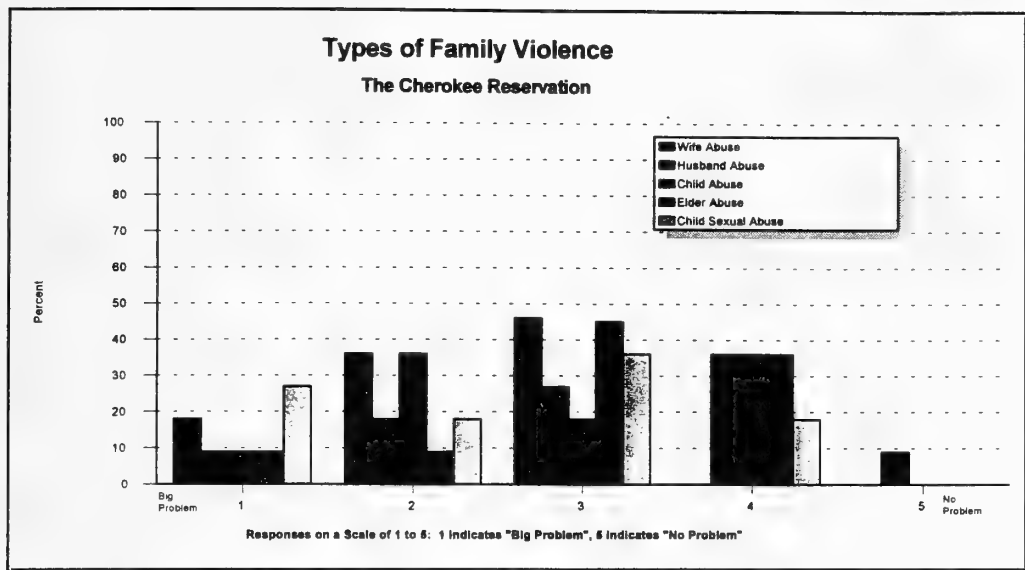


Figure 6. Types of Family Violence (Cherokee)

Regarding general violence, most informants indicated that physical assault without a weapon was the most frequently cited problem, followed by assault with a weapon, and suicide (see Figure 7).

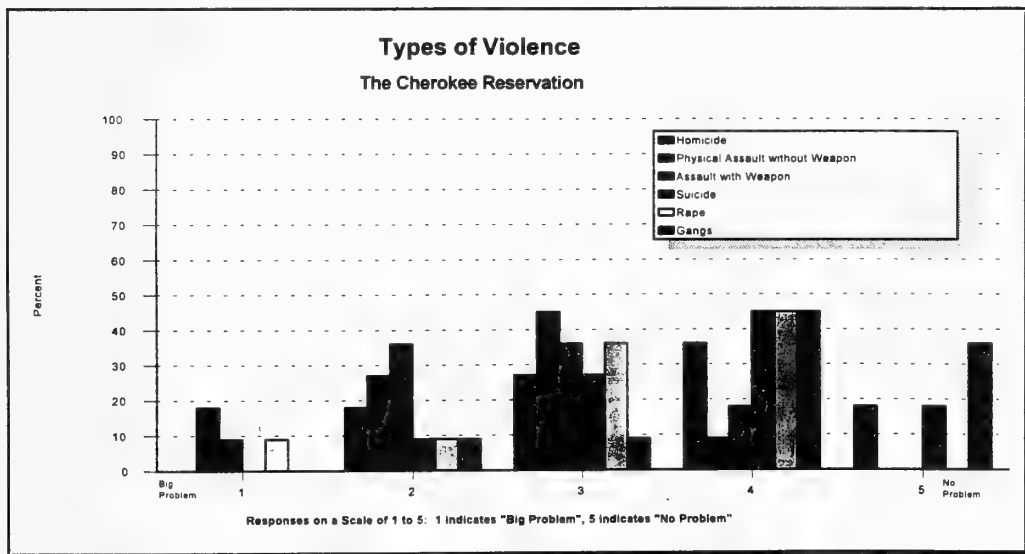


Figure 7. Types of Violence (Cherokee)

The majority of informants indicated that alcohol is almost always a factor in family violence. Defendants are often automatically referred to the Chemical Dependency Unit for alcohol-related offenses. In addition, of the 12 families served by the Cherokee Center for Family Services, ten cases were alcohol related. Treatment of victims of spouse abuse is not well developed.

Almost all informants were aware of shelters in the community for victims of violence; the two most frequently cited were the SAFE shelter and the Children's Home. Over half felt the shelters were above average to average in meeting needs of victims. The majority of agencies and programs had a working relationship with these shelters.

Over half of the informants indicated that efforts to prevent family violence on the reservation are somewhat successful. The majority of the informants indicated that the community is aware of incidents of family violence to some degree, and view it with moderate to little concern. Some informants suggested that this relatively low level of concern about family violence reflects, in part, a denial of the actual scope of the problem at Cherokee (as is common in other communities).

B. Programs/Services

Overall, the informants indicated that resources for victims of family violence were adequate; however, access to these resources was somewhat limited (see Table 1).

Table 1. Availability and Accessibility of Resources for Victims of Family Violence

	1	2	3	4	5
Availability*	9%	18%	45%	18%	9%
Accessibility**	9%	27%	27%	36%	0%
* 1=Excellent, 5=Non-existent					
** 1=Easy Access, 5=No Access					

Approximately half of the informants indicated that they worked with support groups in providing services to victims of abuse. Beyond the actual provision of health care, the most common types of services provided by Federal and tribal staff are counseling and referrals.

1. Programs/Services in Operation

The primary shelter used by the Cherokee is SAFE, Inc. This shelter is located off the reservation, which is preferable to many users. A perceived lack of confidentiality was cited by many informants as a problem for programs on the reservation.

Another often referenced facility is the Cherokee Center for Family Services. Eleven programs are provided through this Center. Services include temporary housing for children, family counseling, food programs, day care, hotline, and foster care. Temporary housing is also provided by the Children's Home; however, there is usually a waiting list for this facility.

Parenting classes and discussion groups are conducted for teenage parents. In addition, a Teen Center offers health programs, counseling, and group education.

2. Additional Programs/Services Needed

Although there are some facilities and services for victims on or near the reservation, informants indicated that there is still a need for additional services and programs (see Table 2). No informant rated the existing family violence programs as successful. A number of informants stated that the reservation was too reliant on outside resources, and that the Tribe should develop on-reservation programs.

Table 2. Efforts to Prevent Family Violence on the Reservation

	1	2	3	4	5
Needed	45%	55%	—	—	—
Successful	—	—	55%	27%	18%
1=Needed 5=Not Needed 1=Successful 5=Unsuccessful					

Area informants indicated a need for specific programs and services as follows:

Pediatric Care. The majority of informants indicated that there is a need for a pediatrician to be on staff at the hospital. They further indicated that infant care for teen mothers is essentially non-existent.

Elder Care. The majority of informants indicated that there is a need for elder care including services such as assistance with health care (taking medications, filling prescriptions, monitoring health care, changes in medication). Informants indicated that medical personnel are frequently indifferent to elders who present for routine health care; these elders often spend long hours in waiting rooms, which could pose a risk for diabetics and patients with high blood pressure.

Law Enforcement Division. Most informants indicated that the tribal police could be more responsive; the law enforcement division is viewed as doing little intervention in domestic disputes. It was frequently cited that the police are slow to respond to family violence cases. Informants further stated that there is a communication problem between the police department and social services. Police recordkeeping and support of the judicial system in the prosecution of cases was seen as inadequate.

Community Education/Awareness Programs. Many of the informants felt that more community education and involvement is needed as well as awareness programs. There is not a clear understanding of assault and battery or other acts of family violence.

Foster Care Networking. A number of informants indicated that there is a need for networking among the foster care facilities. The bureaucracy created by numerous agencies, organizations, and the different government entities (tribal, state, Federal, and county) is a hindrance.

C. Difficulties in Addressing Family Violence Problems

A number of informants stated that community denial is still a problem. There is a lack of education associated with this denial, especially in regard to what the community considers acceptable standards of behavior.

The majority of informants indicated that confidentiality is a major issue. This results in the victims preferring to use off-reservation facilities rather than those available on the reservation.

V. RECOMMENDATIONS

Informants were asked for advice and suggestions to better understand the problem of family violence. A summary of suggestions is presented below.

A. Coordination of Program/Services

There is need for coordination among the different levels of government—tribal, Federal, state, and county. The different agencies and programs are driven by separate protocols and procedures for provision of services for victims of family violence. Often this results in lack of coordination, and conflict over responsibility and jurisdiction. This in turn, results in the victim and the victim's family becoming a "second priority" while issues of jurisdiction and responsibility are resolved. This process ultimately creates confusion for the victim and the family, and can discourage attempts to seek assistance.

Without adding to an already burdensome bureaucracy, an interagency task force could be developed. This would facilitate communication, and clarify roles of all primary parties. Coordination with education and prevention programs for the community and education system could be beneficial to the Tribe.

A service directory listing all available programs, services, and facilities could be developed and routed to all agencies. This directory would contain a description of all services as well as a contact and phone number. This directory should be updated regularly and made available to the community at-large, as well as distributed by the primary service providers.

B. Modify Court System

An issue of utmost concern to members of the Cherokee Tribe is the removal of children from the reservation, and the separation of the child from the family. Notwithstanding the Indian Child Welfare Act, the CFR court generally defers legal action in child abuse, neglect, and custody cases to state or Federal courts. There is a concern that the tribe unnecessarily relies on Federal and state courts.

The court system treats juvenile offenders on a criminal basis and often does not examine the family unit problems. Services for 16-18 year old juveniles are almost non-existent. There is a tribally-operated Juvenile Intake Program. Tribal and community ownership and support are necessary for

a successful program. Problems should be resolved during the intake phase and evaluated for purpose and objectives.

C. Extended Services for Families

The state does not provide the broad range of services that families need. When social services is no longer monitoring the case, the problems usually resume. For example, after families regain custody of their children, problems within the family are often not resolved and resurface in the courts or within social services. Tracking and follow-up should be incorporated as part of their treatment protocols.

D. Training/Education

Interdisciplinary training programs are needed for the providers of services to victims of family violence. This training would include health care providers, social service personnel, police officers, courts, mental health staff, etc. The training should improve communication and coordination between the various members and agencies. This type of training would provide learning opportunities for social workers who may not understand the legal aspects of prosecuting family violence cases; police officers who are unfamiliar with intervention techniques for victims of spouse, elder, or child abuse or for physicians who may not understand legal aspects of expert testimony and effective case finding; and/or interested individuals who serve as volunteers for victims assistance programs, and crisis intervention/prevention. Understanding and coordination among various providers is critical to the reduction of family violence.

A school-based prevention program for grades K-12 should be implemented. Acts of family violence are repeated, and the cycle perpetuated when children are given the message "its okay to beat someone up." The child may witness family violence in the home by siblings, parents, and even through other friends. A prevention program, integrated with the school curriculum, can change the behavior and attitude of children.

There is a need for parenting classes to avoid conditions and situations that may lead to violent acts. The teen pregnancy rate in Swain County is the highest of any county in the state. There are currently classes for teen parents, but only for the age range 12-16 years. Classes in parenting skills should be available to any individual who is in need.

E. Reporting Systems

An integrated reporting system, complete with follow-up procedures, would greatly enhance efforts to combat family violence. There are existing reporting procedures for some Federal, state, and tribal agencies. In some cases, there is no intact system for recording cases of family violence. Such a system is particularly important for law enforcement officers, since they are a critical link in the prevention team. This would provide critical data for court, for the history of repeat offenders, etc. Reporting procedures should be clear and comprehensive, and provided in written form to all employees who are likely to encounter suspected abuse or violence. Often, the procedures are vaguely understood, or clearly understood but not written. The staff should be familiar with issues of confidentiality, maintaining patient records, and reporting.

F. Youth Programs/Resources

Employment opportunities for youth are seasonal and tied in with the tourism industry. Thus, in the fall and winter months, there is little opportunity for youth. Those students who make failing grades or do not meet other requirements for school sponsored sports or activities are excluded. Damaging public property is one of the most frequently cited offenses by juveniles. It was suggested that more activities be provided by the schools, juvenile programs, and Teen Center programs for youth during these months.

G. Elder Care

Elder abuse is the least often reported category of abuse. Reporting is often done by other programs, not by elders themselves. The issue of elder abuse may often be denied by the victim and thus disputed by both parties (the victim and offender). Elders are often the last to complain about lack of resources, services, and finances. There are often special needs of elders (e.g., refilling prescriptions, rendering daily medications, administering outpatient health care, and other necessities). In the absence of a community health nurse or other medical person, family members are often responsible. One of the recommendations was for elder sitting services. Volunteers or community service workers are two possible options.

H. Skills Development

Victims who depend on their perpetrators for financial security are more vulnerable in filing charges against perpetrators, dropping charges or returning to an unsafe home. As part of their counseling,

training programs or referrals to job development programs should be developed for the victim to help enhance independence and self-esteem.

The Tribe should develop positive ways of supporting victims and encouraging them to cooperate with and pursue prosecution of abusers. These positive approaches should supplant the fees currently charged to victims who fail to pursue prosecutions.

ATTACHMENT 3

NAVAJO NATION CASE STUDY REPORT

A CASE STUDY OF FAMILY VIOLENCE IN FOUR NATIVE AMERICAN COMMUNITIES

THE NAVAJO NATION

I. INTRODUCTION

Support Services International, Inc. (SSI) under contract with the Indian Health Service (IHS) conducted a case study on family violence on American Indian reservations. As part of the study, case study site visits were conducted to four geographically and culturally diverse Indian communities. The case study sites included the Rosebud Sioux Tribe, the Confederated Tribes of Warm Springs, the Navajo Nation, and the Eastern Band of Cherokee.

The purpose of the site visits was to collect primary and secondary data concerning 1) the prevalence of family violence, 2) the factors perceived to influence family violence, and 3) the intervention/prevention measures in place and/or under consideration. Secondary data were obtained from tribal programs, the IHS, the Bureau of Indian Affairs (BIA), state, and other programs.

This report is a summary of the site visit conducted at the Navajo Nation. It is important to note that while no single reservation or community is representative of any other, the results of this site visit should be of value as a case study of family violence in American Indian communities.

II. METHOD

The four case study sites were selected using the following criteria: 1) geographic and cultural diversity, 2) willingness of the tribe to participate in the study, and 3) availability of relevant data.

Once the tribes agreed to participate, a point of contact was established. Through a joint effort, a site visit protocol and itinerary were developed for on-site data collection.

Data were collected through 1) unstructured interviews with key informants including representatives from tribal, Federal, state, and other programs, and 2) review of secondary data sources. A discussion of each data source is presented below.

A. Unstructured Interviews of Key Informants

Representatives from tribal and other programs focusing on family violence (e.g., social services, mental health, judicial, law enforcement, medical, and education system) were interviewed. Due to the vast size of the Navajo Reservation, four sites were visited. They are Window Rock (location of Administrative Offices), Chinle, AZ, Crownpoint, NM, and Ft. Defiance, AZ. Unstructured interviews were conducted with 33 key informants:

Crownpoint :

- Jones Begaye, Jr., Police Captain
- Michelle Begaye, Child Advocate, IHS Crownpoint Health Care Facility
- Ernest P. Bennally, Medical Social Services, IHS Crownpoint Health Care Facility
- Juanita Dennison, Director, Agency on Aging
- Judge Mae Horseman, Navajo Nation Family Court
- Johnny Johnson, Emergency Medical Services, Service Unit Manager, Crownpoint Health Care Facility
- Joan Klonowski, M.D., Mental Health, IHS Crownpoint Health Care Facility
- John Perry, Jr., President, Crownpoint Chapter House
- Verna Tsosie, Director, Family Harmony

Window Rock:

- Vivian Arviso, Executive Staff Assistant, Office of the President & Vice-President
- Raymond Austin, Associate Judge, Supreme Court
- Georgia Crawford, Director, Navajo Nation Division of Family Planning
- Elmer Guy, Deputy Director, Navajo Nation Division of Education
- Genevieve Jackson, Chairperson, Health and Human Services Committee
- Sally Jo, CHR Supervisor
- Adele King, Women, Infants, and Children Program
- Albert Long, Director, Division of Social Services
- Tully Mann, Deputy Director, Navajo Area Agency on Aging
- Ed Martin, Court Administrator
- Captain Steven Nelson, Division of Public Safety, Department of Law Enforcement

- Mr. Sabala, Legislative Services
- Ella Shirley, Social Worker, Navajo Division of Social Services
- Lori Thompson, Legislative Advisor
- Harold Tunney, Community Services Coordinator
- Henry Wallace, Program Director, Emergency Medical Services
- Sandra Watts, Public Defender
- Evangeline Wyaco, Office of Navajo Women
- Calvin Yazzie, Chapter Officer, Court Advocate
- Herb Yazzie, Attorney General

Chinle Service Unit:

- ADABI Home for Mothers and Children
- Leona Leonard, Chinle Youth Home
- Don F. Mitchell, Alcohol & Drug Counseling, Family Counseling (CADAC)
- Christina O'Shea, DNA People's Legal Services, Inc.

Discussions with key informants, ranging from 50 to 90 minutes, were conducted over a 5-day period, July 26-30, 1993. Each informant was interviewed separately by contractor (SSI) staff. After the discussions were completed, the interviewers prepared a summary of the information collected. An exit interview was conducted with the Health Administrator, and the major issues and questions that emerged from the site visit were presented and discussed. Finally, the draft of this Case Study Report was submitted to the principal tribal contact (the Tribal Health Administrator) for review and feedback. This case study report reflects the feedback obtained from the tribal reviewers.

B. Sources of Secondary Data

The following documents were collected and reviewed:

- ADABI, Home for Mothers and Children, Program Description
- Alternatives to Violence, Chinle, IHS, Program Description
- Brochures: Standing Committees of the Navajo Nation Council, Council Delegates, Three Branch Government of the Navajo Nation, Speaker of the Navajo Nation Council, Navajo Tribal Code
- Child Protection Team (CPT) Monthly Summary of Reported Cases (October, November, and December 1993)
- Crownpoint Comprehensive Indian Health Facility, Program Description

- Domestic Violence Code
- Example of Medical Incident Report - NEMS
- Navajo Nation Child Protection Team (CPT) Protocol
- General Information Services Sheet, NEMS
- NEMS Protocol, General Order 26-88
- OEDP, The Navajo Nation, 1991
- Organizational Charts, NEMS, Navajo Area Agency on Aging

III. TRIBAL PROFILE

The Navajo "Dineh" once led a semi-nomadic life style in the area now known as the southwestern U.S. There are several events throughout the history of the Navajo that have had a profound effect on their culture today. For example, in 1680 the Navajo supported the Pueblos against the Spanish conquerors in the "Pueblo Revolt." This alliance resulted in a variety of changes for the Navajos—increased numbers, exposure to the new skills of weaving and sheepherding.¹ The Navajo were very adept at selectively incorporating into their lifestyle positive attributes of other bands of Indians.

In the 1800's, the influx of European settlers brought tremendous change to the Southwest. Although the Navajo fought to maintain control of their territory, their efforts were not realized. In 1863, the U.S. Government undertook a campaign to defeat the Navajo. As part of this campaign, in 1864, the Navajo were forced to undergo the "Long Walk." This was the beginning of a failed attempt by the U.S. Government to relocate over 8,500 Navajos to a place known as "Bosque Redondo." The Navajo could not adjust to this barren location that could not support their way of life. The Navajo spent 4 years in Bosque Redondo before the U.S. Government acknowledged its error in judgment and permitted the Navajo to return to their homeland. By 1868, the Navajo Reservation had been established.

Located in the "four corners" area of Arizona, New Mexico, Utah, and Colorado, the Navajo Nation is the largest Indian reservation in the United States (see Figure 1). The Navajo Reservation encompasses approximately 26,187 square miles and has three distinct climates: cold and humid (8%), intermediate steppe (37%), and arid desert (55%). The altitude ranges from 5,500 feet to more

¹Canyon De Chelly: The Story Behind the Scenery. KC Publications, Inc. 1990.

than 10,500 feet. The reservation has many spectacular sites such as Canyon de Chelly, Shiprock, Monument Valley, the Chuska Mountains, and the Painted desert.

There are approximately 200,000 members of the Navajo Tribe. According to the U.S. 1990 Census, 151,105 people reside on the Navajo Reservation, and half the remainder reside in the border areas surrounding the reservation.

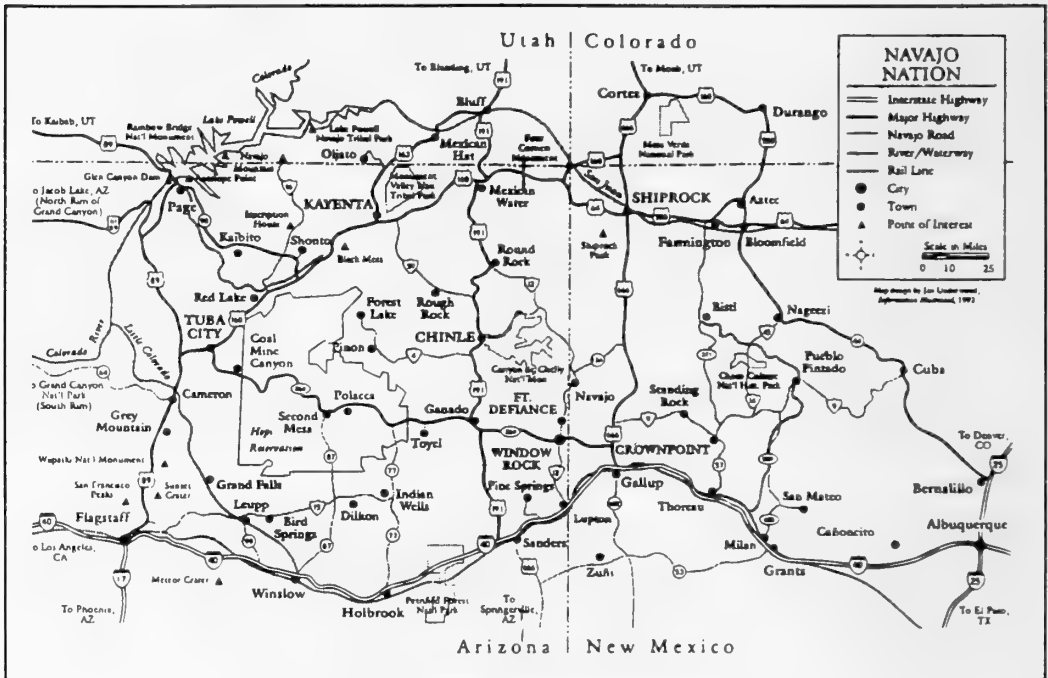


Figure 1. Location of the Navajo Reservation

The Navajo Nation's most recent Overall Economic Development Plan (OEDP), dated December 1991, indicated that the potential labor force was 50,368, and the number of persons employed was 31,975. Based on these figures, the unemployment rate for the Navajo Nation in 1991 was 36.5 percent. The 1991 OEDP also reported a per capita income of \$5,958 for the Navajo Nation, and a median age of 22.3 years.

The Navajo Nation is rich in natural resources. The major components of the resource base are land, water, and minerals. There are substantial deposits of mineral resources including coal, uranium, oil, and gas. Mineral royalties on tribal trust lands exceeded \$49 million in 1991. The reservation also has large stands of ponderosa pine which yield valuable timber. These timber resources are jointly managed by the Navajo Nation and the BIA. The Navajo Forest Products Industries (NFPI) reported

timber sales of over \$16 million for 1991, and over \$21 million for 1992; however, there is a controversy regarding the profitability of NAPI. Timber resources provide employment, as well as revenue for the Tribe.

The Navajo Nation supports seven industrial parks; four are located in New Mexico (Shiprock, Shushbetoh, Church Rock, and Farmington), and three are located in Arizona (Fort Defiance, Chinle, and Leupp). The tribal industrial parks support many industries located within the reservation. The Navajo Nation also utilizes tax revenues, such as the Mineral Severance Tax, Business Activity Tax, Possessory Interest Tax, and the Hotel Occupancy tax, as a viable sources of income to support the general government administration services.

There are six tribally-operated shopping centers located in the towns of Window Rock, Tuba City, Kayenta, Shiprock, Crownpoint, and St. Michael's. There is also one non-profit community development corporation developed by Dineh Cooperatives in Chinle. The complexes located at Kayenta and Shiprock include office space for shopping center management and small business assistance. Twelve percent of all revenues are set aside in a trust fund for future Navajo generations.

An outgrowth of an irrigation project of the 1960's (Navajo Indian Irrigation Project), "the Farm" produced sales in excess of \$31 million in 1990. The Farm is run by a tribal enterprise called the Navajo Agricultural Products Industry (NAPI). Through NAPI's management plans and crop diversity, NAPI has become a profitable resource for the Tribe.

The Navajo refer to themselves as the Naho Ka'a Dine (Earth Surface People). Fundamental to the Navajo perceptions of the universe is the all inclusivity—spirituality, health, harmony, and beauty are one and are inseparable affecting all the good things in life. The Navajo "religion" is complex and the interrelatedness of all spiritual and daily activities helps to reinforce the complex, esoteric, and aesthetic beauty of the ceremonials. Today, like many other American Indian tribes, the Navajo are caught in a cultural dilemma where the traditional "religious" values are heavily influenced by Christianity and other American Indian religions. The reservation is dotted with fundamental Christian revival tents and with tepees representing the Native American Church. Several informants commented on the "religious wars" that were taking place on their reservation. Many of the traditional medicine men attribute most of the social ills, i.e., child abuse, family violence, alcoholism, etc., on the people straying from the traditional ways.

A. Government

In 1923, the first formal "western" government structure for the Navajo Nation was established. This "Business Committee" was established by the Secretary of Interior as a vehicle for obtaining approval from the Navajo for the lease of their oil. Six delegates and six alternates were selected to serve on this Business Committee. The focus of Federal Indian policy in the 1930's permitted tribes to take greater control over their affairs. As a result, the first Navajo Tribal Council was formed. It was comprised of 12 delegates and 12 alternates.

Over time, the structure of the Navajo Nation government has changed as self-sufficiency and laws governing the Tribe evolved. The current laws governing the Navajo Nation are specified in the Navajo Tribal Code. The current government structure of the Navajo Nation has three branches: Legislative, Executive, and Judicial. This three-branch government was established by resolution on December 1989 and became operational in April 1990 (see Figure 2).

The Executive Branch is comprised of a President (who serves as the Chief Executive), a Vice-President, and appointed officials. Their role is to administer and enforce laws passed by the Legislative Branch and to deliver services.

The Legislative Branch consists of the Navajo Nation Council and any entity established under its authority. The Navajo Nation Council is the governing body of the Navajo Nation. This Council consists of 88 delegates who are elected by the voters of the 109 chapters of the Navajo Nation. A chapter is similar to a town hall where people meet periodically to discuss issues of local concern; chapters have the authority to develop local resolutions.

The Judicial Branch is headed by the Chief Justice and oversees all judicial activities including the Navajo Nation's courts. Further information on this branch is provided.

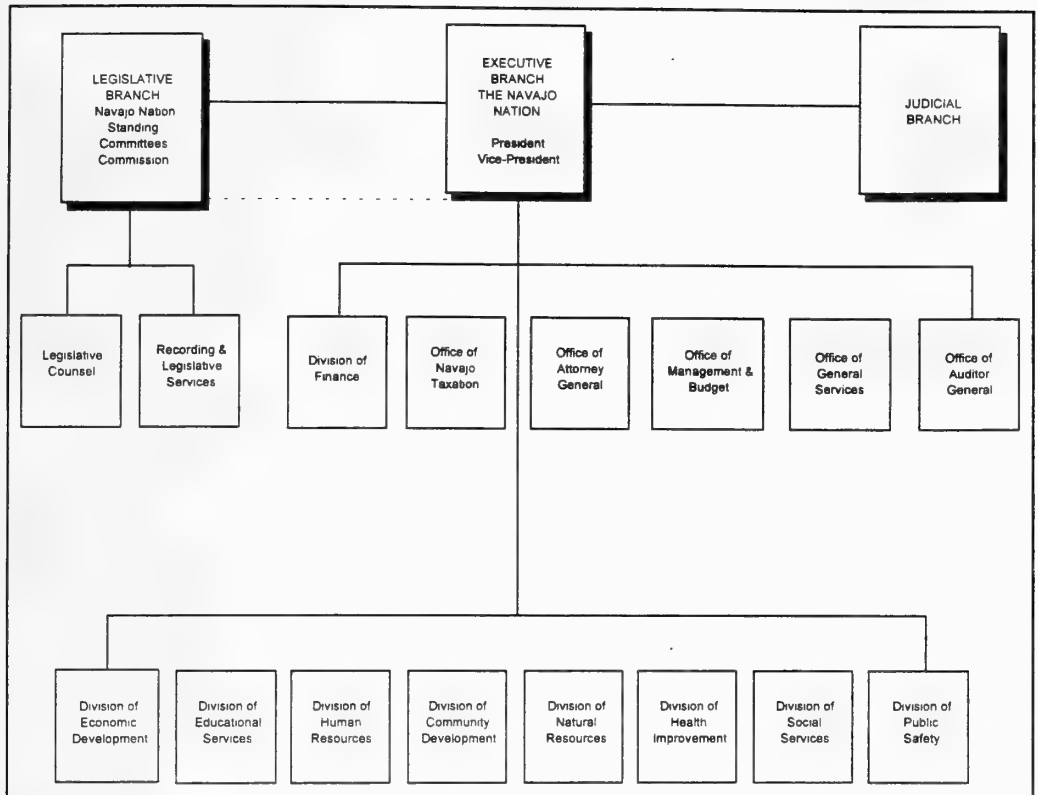


Figure 2. The Navajo Nation Organization Chart

The Navajo government has become a complex, multi-level bureaucracy viewed by many as cumbersome. The tribal government is located primarily in Window Rock and Fort Defiance, AZ. Some informants reported that the Navajo have a word for Window Rock which translates to "come back tomorrow." This reflects the effort sometimes required in resolving issues involving the Navajo bureaucracy.

B. Judicial System

The Navajo Nation operates a two-level court system—the trial courts, and the Navajo Nation Supreme Court. The role of the judicial system is to apply and enforce laws made by the Navajo Nation Council. Cases begin in the trial courts, with appeals of trial court decisions made to the Supreme Court—the court of last resort of the Navajo Nation. The trial courts consist of seven

judicial districts, each of which has a district court. Five of the judicial districts have a separate family court.

The Navajo judiciary is made up of 17 judges; 14 are trial judges who preside in the trial and family courts, and three are appellate judges who preside in the Supreme Court. One appellate judge is the chief justice and the other two are associate justices. It is noteworthy that 7 of the 17 judges are women.

The Navajo Family Courts have jurisdiction over matters involving children, probate, domestic relations, etc. Figure 3 illustrates the structure of the judicial system of the Navajo Nation.

Members of the tribe can also use the Navajo Peacemaker Court to solve disputes. This court is attached to the trial courts and uses Navajo traditional laws and procedures in a Navajo mediation setting to arrive at consensual solutions to disputes. Chapters (the most local form of political organization in the Navajo Nation) have the ability to legislate on local problems (e.g., stray animals, litter, and causes of community disruption), but few know how to use that power. The Navajo Peacemaker Court rules give chapters the ability to hold community-wide meetings to deal with disruption. The Judicial Branch seeks ways to re-empower Navajo Nation communities at the chapter level in the Navajo Peacemaker Court.

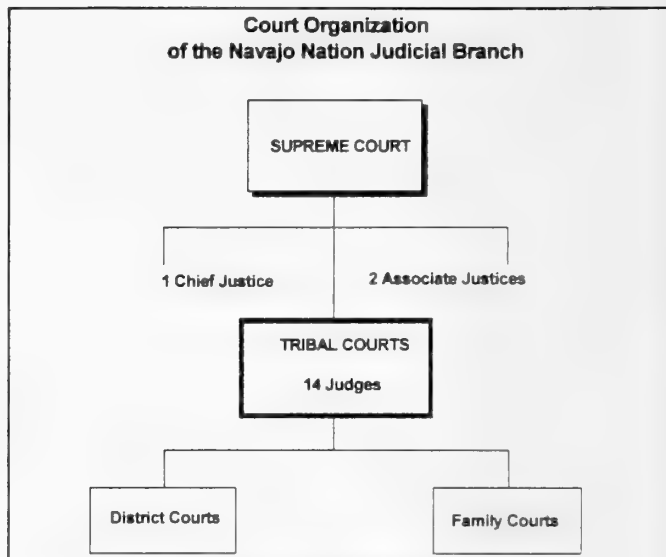


Figure 3. Structure of the Navajo Nation Judicial Branch

Navajo common law is the law of preference in the Navajo courts. Otherwise, Federal law, if applicable, is used; state law may be applied last.

In July 1993, the Navajo Nation enacted the Domestic Violence Prevention Act. The Act is designed to protect all persons from all forms of domestic violence as defined by the Act and the Navajo Nation. This includes men, women, children, elders, disabled persons, and other vulnerable persons

who are within the jurisdiction of the Navajo Nation. This Act states that domestic violence is a crime, contains provisions for relief, outlines penalties for perpetrators, and mandates reporting and evaluation.

The Judiciary Committee of the Navajo Nation Council approved comprehensive court rules to deal with domestic violence on October 2, 1992. Both those rules and the 1993 Domestic Abuse Protection Act are perhaps the most comprehensive laws to deal with violence within families in the United States. The definition of "domestic abuse" includes broad categories of acts, including all Navajo Nation offenses and acts which would be intentional torts. The Navajo Nation law, unlike many jurisdictions, recognizes that children are the "tag-along" victims of family violence.

C. Law Enforcement

The Navajo Division of Public Safety has six (6) Departments with 700+ employees. The Navajo Department of Law Enforcement is the largest Department with approximately 400 employees. The Navajo Department of Law Enforcement has seven (7) Police Districts in each community of Shiprock, New Mexico, Crownpoint, New Mexico, Tuba City, Arizona, Chinle, Arizona, Kayenta, Arizona, Dilkon, Arizona, and Window Rock, Arizona. There is a Captain's position in each District and one overall Chief of Police for the Department. All the Districts have Detention facilities with the exception of Dilkon, Arizona.

During the site visit, representatives from the law enforcement division canceled their meetings with the data collection team. It was not possible to reschedule meetings with them. Likewise, efforts to obtain secondary data directly from the law enforcement division were unsuccessful. The information regarding the law enforcement division was obtained from other informants and through secondary data from the Social Services Division.

The Navajo Nation Division of Law Enforcement began keeping records of reported cases of child abuse in January 1991. Comparison of the records for 1991 with 1992 showed a significant increase in reported cases over a 12 month period.

Spanning portions of three states, the Navajo Nation consists of over 17 million acres. This land area is divided into five geographic "agencies" representing portions of the reservation. The Eastern Navajo Agency is checkerboarded with portions of land governed by state or county laws. In addition to tribal laws, there are laws of three states and the various counties within each state. The

vastness of the reservation and the many governing entities frequently create jurisdictional problems for law enforcement personnel.

D. Social Services

The Navajo Division of Social Services has the responsibility to plan, develop, administer, and deliver social services to Navajo families and individuals living within or bordering the Navajo Nation boundaries. Social Services was established as a separate Division in 1989, and is accountable to various tribal, state, and Federal funding sources as well as to the Navajo Nation Council. The Division administers several programs including Family Violence Prevention Services, programs under the Indian Child Welfare Act (ICWA), Child Foster Care Program, the Navajo Child Abuse and Neglect Project, Protective Services to Children, and Family and Community Services. The Division of Social Services has been a family violence prevention grantees since 1986.

The Navajo Nation has multidisciplinary Child Protection Teams (CPTs). The level of effectiveness of the CPTs varies among the Navajo agencies. This is due, in part, to jurisdictional issues and to the remoteness of much of the population. In October 1993, a resolution was passed approving a protocol for the CPTs. The CPT teams involve the following members:

- The Division of Social Services CPT social worker/primary social worker
- IHS physician, social worker, mental health worker, community health nurse
- BIA school social worker/counselor
- Public school social worker/counselor
- Navajo Law enforcement (police officer/investigator)
- Navajo Office of the Prosecutor
- Navajo Department of behavioral Health/IHS substance abuse counselor

The protocol outlines the roles and responsibilities for each member of the CPT team. It further specifies that comprehensive primary and secondary child abuse and neglect prevention programs shall be developed to positively influence individuals and environments before abuse and/or neglect occur.

E. Health Care Services

The IHS administers and provides health care services to the Navajo. Comprehensive health care is provided through inpatient, outpatient, contract, and community health programs centers around 6 hospitals, 7 health centers, and 12 health stations. School clinics and Navajo tribal health programs also serve the community. The hospitals range in size from 39 beds in Crownpoint to 112 beds at the Gallup Indian Medical Center. Other IHS operated hospitals serving the Navajo Nation include Chinle, Ft. Defiance, and Tuba City in Arizona, and Shiprock, New Mexico.

Health centers operate full-time clinics, some of which provide emergency services. IHS operates health centers located in Kayenta, Inscription House, Tsaile, Teec Nos Pos, AZ; and Winslow in Arizona, and Bloomfield and Tohatchi, New Mexico. Some of the smaller communities on the Navajo Reservation have health stations or environmental health field stations that operate on a part-time basis. They are located in Flagstaff, Ft. Defiance, Kayenta, Many Farms, Tuba City, Window Rock, Winslow, Arizona, and Crownpoint, Farmington, Gallup, and Shiprock, New Mexico.

The Navajo Department of Health (NDOH) is an important component of the Navajo Nation health care delivery system. The NDOH is tribally-sponsored and was created in 1977. NDOH's mission is ensuring that quality and culturally-acceptable health care is available and accessible to the Navajo people through coordination, regulation, and direct service delivery (if necessary). The NDOH also provides a variety of health-related services in the areas of nutrition, aging, substance abuse, emergency medical services, and outreach (Community Health Representative Program).

F. Education

There are four major educational systems serving the Navajo Nation. Within these systems are a total of 243 schools: 160 public schools; 47 BIA schools; 18 contract and grant schools; and 18 mission schools. There are a total of 68,092 students enrolled in the school system. Enrollment statistics by school category are 48,000 (80%) in public schools; 13,961 (14%) in BIA schools; 3,910 (4.5%) in contract and grant schools, and 2,221 (1.5%) in mission schools. In addition, there are five special education schools serving 873 students in Chinle Valley, AZ, St. Michaels, AZ, and Toyeyi, AZ, Coyote Canyon, NM, Tohatchi, NM.

The Navajo Nation operates a Head Start Program which serves approximately 4,036 students. Established in 1965, the Head Start Program offers early childhood education at 156 centers serving children throughout the Navajo Nation.

The first public school on the Navajo Reservation was established in 1911. Before that time, there was a general consensus that the "outsider's" concept of education did not mesh with the lifestyle and beliefs of the Navajo Nation. In 1965, the first Head Start Program was established, followed by the Rough Rock Demonstration school which was contracted through the Buy Indian Act in 1966. Shortly after, in 1968, the Navajo Community College was established. The Navajo Nation Department of Education was established in 1971. The Education Committee is responsible for overseeing the education development of the Navajo Nation, and to develop policies for a scholastically excellent, and culturally-relevant education. The Committee consists of a chairperson, one vice-chairperson, and six members.

There are two institutions of higher learning located on the Navajo Reservation. Located in Crownpoint, NM, the Crownpoint Institute of Technology is a vocational/technical training center. The Navajo Community College, located within the boundary of the Navajo Nation, is chartered and operated by the Navajo Nation, and offers 2-year programs. The main campus is located in Tsaile, Arizona with branches in Shiprock and Crownpoint, New Mexico, and Ganado and Window Rock, Arizona.

There is a referral process within the school system for providing assistance to children who are abused and/or neglected. The steps, in sequential order, include notification of the school principal, notification of the superintendent, law enforcement, IHS, and finally tribal social services.

G. Programs/Resources

Examples of programs/services available to Navajo residents include:

1. ADABI (Ama Doo Alchini Bighan, Inc.). Located in Chinle, ADABI is a private, non-profit family crisis program whose mission is to provide comprehensive, culturally-sensitive services to mothers and children who are victims of family violence. The program was established in 1989 and has served more than 400 families. The majority of clients include Navajo (94 percent), other American Indians (3 percent) and Anglo (1 percent). Clients are not limited to the Chinle Area; services are extended to 21 other Navajo communities as well.

ADABI offers a 24-hour crisis program for victims of family violence. Outside of regular business hours, clients can usually reach someone through the local emergency room or police department which usually contacts a volunteer by phone or beeper. Volunteers will then meet the client at the

emergency room or police department. Services include crisis counseling, safehouses, transport to shelters, assistance in accessing local services such as police, legal, counseling or social services.

ADABI also offers community education services including presentations to communities, schools (with a focus on high school) agencies, and organizations. Education programs focus on the dynamics and prevention of family violence, comparison of healthy and abusive relationships, and techniques for prevention of violence.

2. ATV (Alternatives to Violence Program). This is a 12 week cultural-based treatment program designed for victims of family violence. It is funded through the IHS, Chinle Comprehensive Health Care Facility. Weekly sexually segregated sessions are held for groups of 8-12 clients. The focus is on behavioral modification; the male group concentrates on learning ways to avoid "blow-ups" that result in abuse, and the female groups focus on behaviors to avoid becoming a victim of abuse. Referrals are usually received from the Navajo tribal courts, social services, and other service providers.

The treatment is designed to change violent behaviors into alternative non-violent behaviors by couples who have experienced family violence. The sessions are conducted by trained American Indian therapists, and are usually for 8-12 clients. This program was modeled after a similar successful program in Tuba City, Arizona.

3. DNA People's Legal Services, Inc. is the largest Native American Legal Services program in the country. DNA's central administration office is located on the Navajo Nation. Other offices are located in Tuba City and Chinle, Arizona; Shiprock and Crownpoint, New Mexico; and Mexican Hat, Utah. Each office is staffed by attorneys and by Navajo and Hopi tribal court advocates. Tribal court advocates are members of the Navajo or Hopi Tribes who are licensed to practice law in the courts of the Navajo Nation and the Hopi Reservation. The support staff are bilingual in Navajo and English, and Hopi and English.

DNA provides legal services in the areas of consumer law, family law, administrative law, public entitlements, and Federal Indian law to low income people who live in and around the Navajo and Hopi reservations. It also provides educational programs through local community organizations such as chapters, villages, and schools. DNA was incorporated in Arizona in 1967, and for 2 years was a delegate agency of the Office of Navajo Economic Opportunity until 1969 when it became an independently funded program. DNA now operates under the direction of a 21-member Board of

Directors and is funded by the Legal Services Corporation, the Arizona Bar Foundation, and the New Mexico Bar Foundation.

DNA worked closely with the judicial system and courts in developing the Domestic Violence Code for the Navajo Nation.

4. Shelters. There are three family violence shelters located on the reservation. They are located at Kayenta, Arizona; Shiprock, New Mexico, and Navajo, New Mexico. A problem encountered by many potential users of these shelters is one of location. The shelters are far away from many victims who could use them. Oftentimes, there is no transportation available.

IV. FINDINGS

Informants were asked for their perceptions of the severity of general violence and family violence. Graphics in this section summarize the informants' assessments. Although the number of informants was small (33) and may not reflect statistically reliable data, the statistics reported in this section represent valuable qualitative assessments for this study.

A. Prevalence of Violence

In July 1993, the Navajo Nation enacted the Domestic Abuse Prevention Act. The Resolution of the Navajo Nation Council (CJY-53-93) accompanying the Act states:

"2. Domestic violence is occurring on the Navajo Nation in epidemic proportions. Many Navajo persons are beaten, harassed, threatened or otherwise subjected to abuse within the domestic setting; and

3. Domestic violence has a lasting detrimental effect on the individuals who directly experience the abuse and on their children, who carry memories of violence with them into their adult lives and may themselves become violent and abusive;"

General Violence vs. Family Violence

The Navajo Nation

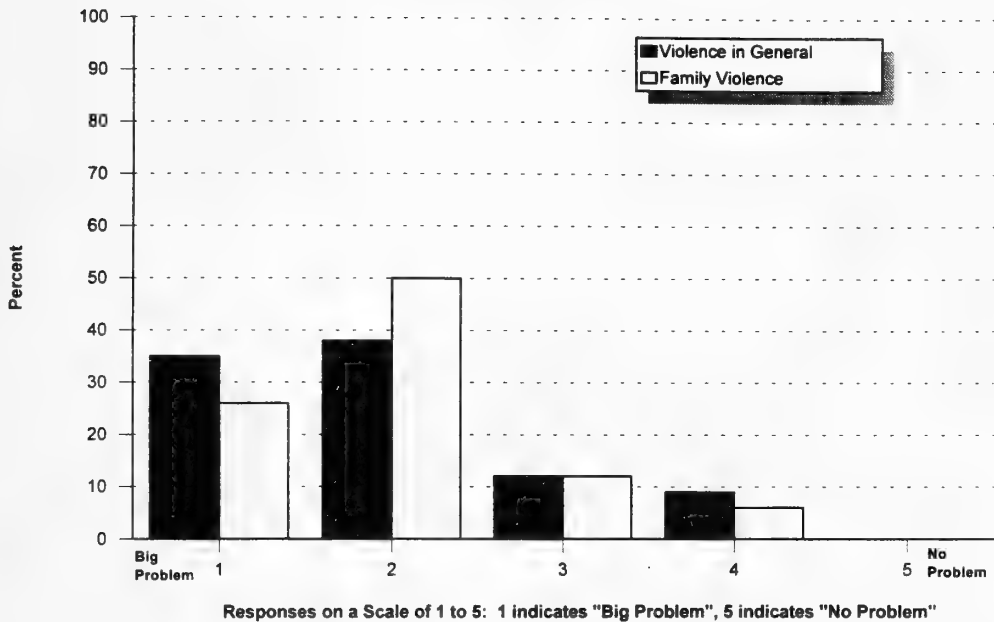


Figure 4. General Violence vs. Family Violence on the Navajo Reservation

The majority of informants indicated that general violence and family violence are judged to be big problems on the Navajo Reservation (see Figure 4). Wife abuse, child abuse, and child sexual abuse were rated as the most common types of family violence (see Figure 5). Elder abuse was also viewed by the majority of informants as being a problem. Informants indicated that the most common categories of elder abuse were verbal abuse, "dumping" (dropping off children for elders to care for, usually for extended periods of time), and neglect.

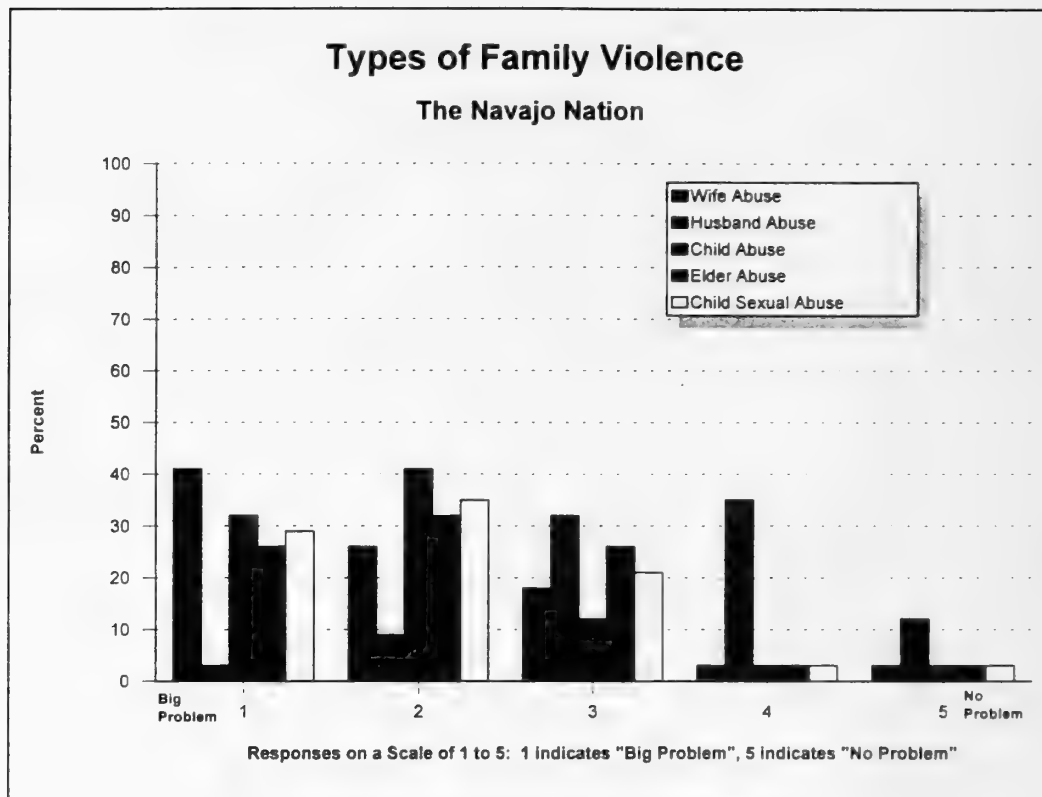


Figure 5. Ratings of Family Violence on the Navajo Reservation

Physical assault (with and without a weapon), rape, and suicide were all judged to be big problems on the reservation (see Figure 6). Most informants (88 percent) felt that alcohol was a factor in family violence.

Types of General Violence

The Navajo Nation

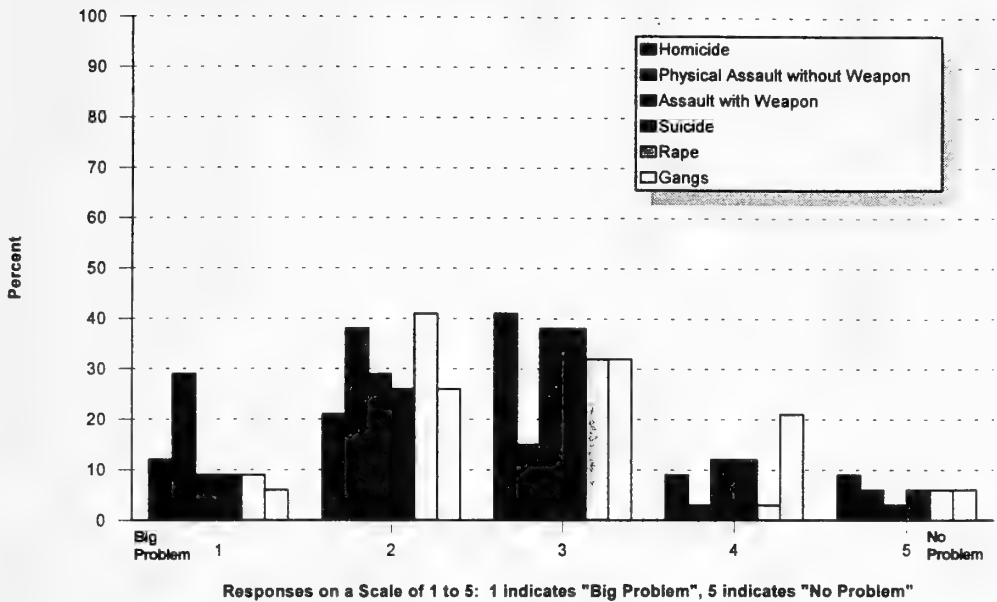


Figure 6. Ratings of General Violence on the Navajo Reservation

Summary Reports, although incomplete, from the Child Protection Team indicate that 387 cases of child abuse and/or neglect were reported for the months of October, November, December 1993 (see Table 1).

Table 1. Reported Cases of Child Abuse for October, November, December 1993

Location	Total	Neglect	Physical Abuse	Sexual Abuse	Emotional Abuse
Alamo	24	22	2		
Canoncito	12	9	2	1	
Crownpoint	22	9	2	11	
Dilkon	99	59	19	17	4
Dzil Na O Dilth	30	28	2		
Ft. Defiance	20	7	10	3	
Gallup	17	6	4	6	1
Ganado	18	8	2	7	1
Kayenta	37	24	11	2	
Shiprock	92	35	29	27	1
Tuba City	16	8	4	4	
TOTAL	387	215	87	78	7
PERCENT		0.56	0.22	0.2	0.02

Table 2 presents a summary of offenses occurring for specified police districts for the period January 1 - December 31, 1991. The total (2,307) represents an increase of 1,610 cases over the 1990 total of 697 cases.

Table 2. Reported Cases of Child Abuse and Family Disturbance for January 1 - December 31, 1993 (Navajo Police Department)

District	Child Abuse/Neglect	Family Disturbance	TOTAL
Window Rock District	160	95	255
Shiprock District	141	123	264
Crownpoint District	244	600	844
Tuba City District	109	363	472
Chinle District	76	128	204
Kayenta District	81	140	221
Dilkon District	14	33	47
TOTALS	825	1,482	2,307

In FY 1993 (April 1, 1992 - March 31, 1993) 47,979 cases were filed in the courts, and 47,979 were brought forward. The total criminal caseload (new filings + cases brought forward) was 46,589 cases. The major categories of offenses were 1) offenses against the public order (36.8 percent), 2) driving while intoxicated (13.5 percent), 3) offenses against persons (13.4 percent), 4) intoxicating liquor possession or sales (12.5 percent) and offenses against the family (5.7 percent). Those categories were approximately 82 percent of the criminal docket. Anecdotal evidence from trial judges tells us that the major offenses against the public order are public intoxication and disorderly conduct. Given limited jail space, public intoxication is no longer prosecuted as an offense. The Judicial Branch has developed a draft code to decriminalize public intoxication. Disorderly conduct is directly related to violence problems, because most often it reflects arrests at drinking gatherings. Often, assaults and other violent behavior are associated with disorderly conduct. Most homicides are associated with traffic crashes, with many women and child victims. Therefore, DWI is a violence issue. Offenses against persons include assaults and batteries, and this is where the judges see family violence. The percentages for offenses against the public order and persons should be combined to paint a general picture of family violence — that up to 50 percent of all cases likely involve drinking and fighting; up to 23,402 matters of the caseload.

While this analysis is somewhat speculative, the National Research Council's 1993 study, Understanding and Preventing Violence concludes (at page 198) that "Intoxicated Navajo fight almost exclusively with family members." (The Council does not cite the source for that statement.) That supports the conclusion that Navajos are primarily dealing with alcohol-related assaultive behavior in our criminal cases.

The figures for child neglect and abuse shows that in FY 1993, 428 petitions were filed and 346 cases were brought forward for a total caseload of 774 matters. The greatest category of cases was physical abuse or neglect (55.1 percent). Interestingly, the second greatest category was guardianships (15.3 percent). That reflects the fact that Navajo grandmothers and aunts are seeking private remedies for mistreatment of children.

Most informants indicated they deal with family violence, in some capacity, on their job. Encounters most commonly reported were crisis intervention, referrals, counseling, provision of legal services, and provision of health care (including transporting victims of abuse).

Many informants indicated that most people on the reservation are aware of family violence and view it as a problem; in addition, many cases of family violence are not reported.

B. Programs/Services

Despite the prevalence of family violence on the reservation, informants indicated that resources and programs for addressing the problem were limited. Most existing programs focus on crisis intervention rather than prevention. There were conflicting reports on the availability of shelters for victims of abuse. Documents from the Division of Social Services report that there are three shelters on the reservation for victims of family violence; however, a number of the informants indicated that there are no shelters for victims of abuse on the reservation—the shelters are located off the reservation. These informants stated that the shelters are not easily accessed by residents of the Navajo Reservation. Confusion concerning availability of shelters and programs as well as protocols for accessing these resources are concerns expressed by a number of informants.

Responses to questions on availability and accessibility of resources for victims of family violence indicated that resources were limited and viewed as inaccessible by most informants. Table 3 summarized the findings.

Table 3. Availability and Accessibility of Resources for Victims of Family Violence

	1	2	3	4	5
Availability*	3%	0	18%	53%	21%
Accessibility**	0	3%	24%	44%	23%
* 1=Excellent 5=Non-existent					
** 1=Easy Access 5=No Access					

1. Programs/Services in Operation. There are options for immediate help for victims of abuse. However, due to the vastness of the Navajo Reservation, accessibility is often a problem. Isolation makes access to all tribal resources--medical, law enforcement, and social services difficult.

There is a variety of services and resources available to victims of family violence on the Navajo Reservation. There are shelters on and near the reservation, safe houses, foster care, etc. There are Federal and tribally-operated programs for women only, men only, and the family as a whole. There are legal services available to the Navajo, helping with temporary restraining orders as well as general legal assistance.

The recently enacted Domestic Abuse Prevention Act, if implemented and enforced, has great potential for reducing family violence on the reservation.

2. Additional Programs/Services Needed

Table 4. Efforts to Prevent Family Violence on the Reservation

	1	2	3	4	5
Needed*	65%	26%	3%	—	—
Successful**	3%	6%	26%	41%	15%
*1=Needed	5=Not Needed				
**1=Successful	5=Not Successful				

The majority of informants indicated that there is a need for prevention efforts on the reservation, and viewed the current attempts of reducing and preventing domestic violence as unsuccessful (see Table 4).

The informants suggested a number of areas for additional programs to address family violence. These areas include:

Community Awareness Programs. These programs should focus on factors and dynamics related to family violence. It was recommended that a program be implemented for the K-12 school system. This program would focus on the identification and prevention of family violence. Early education of children regarding issues related to this problem could help break the cycles of violence.

Training for Peacemaker Court. Some informants indicated that there is variation across the Navajo districts on the effectiveness of the Peacemaker Court. Training is recommended on the consistency in application of laws and traditions, and conducting hearings in an objective manner. It was reported by some informants that the Peacemaker Court can actually work against the victim. For example, Peacemaker Court may be attended by family and friends of the defendant (perpetrator), who will support the perpetrator and blame the victim. On the other hand, a solicitor in the Judicial Branch argued that peacemakers are well aware of the potential of revictimizing women in the process. The traditional procedures of peacemaking are designed to support victims by involving the victim's family. Peacemakers know how to intervene on behalf of victims. These principles are being used in ongoing training for peacemakers, and the planned training required by the Domestic Abuse Protection Act of 1993.

Navajo Traditions and Values. Education in Navajo traditions and values, including family values, is considered by many to be a critical need. Findings from a study conducted by the Navajo Nation during the past 5 years indicate that 70 percent of Navajo youth did not speak the Navajo language, and many did not know or practice traditional customs and values. The involvement of tribal elders in teaching traditional values and traditions was viewed as an effective prevention measure.

Informants indicated that this cultural loss was brought about, in part, by the boarding schools. This experience resulted in a "lost generation" where children were separated from parents, grew up without parents, under the supervision and administration of boarding school staff. Examples set for conflict resolution and discipline involved corporeal punishment, and other violent measures. Growing up without examples of parenting skills and without the love and support of the parents and grandparents had a profound impact on this generation. Many became parents without the benefits of a parent-child relationship, and without knowledge of parenting skills.

Parenting skills. Many informants indicated that there is a need for training in parenting skills. This would focus on communication, discipline techniques, parent involvement, conflict resolution, etc.

One informant stated that the Judicial Branch recognizes the shortcomings of the police and social work models of violence prevention. There are not enough police to cover an area which is rural and almost as big as South Carolina. On any given night, the Chinle Agency is covered by two squad cars. Social workers are overburdened with sex abuse cases and cannot address the major category of child abuse—"dumping" children on the elderly or leaving them alone at home or in a vehicle. Navajos seek private remedies to prevent or escape violence, including domestic abuse restraining orders, peacemaking, guardianships, and divorce. While the Judicial Branch wishes to offer those remedies to people without the need for a lawyer (because most Navajos cannot afford a lawyer), the Navajo Nation general funds are insufficient to provide the staffing and equipment to offer them. The Federal Government, including the BIA and IHS, does little to support such initiatives. The informant stated that BIA and IHS officials refuse to participate in Navajo Nation court proceedings to protect children, and will not honor court decrees for treatment and services.

C. Difficulties in Addressing Family Violence

A number of informants indicated that there are two commonly practiced behaviors that impede efforts for the prevention/intervention of family violence on the Navajo Reservation. They are 1) denial, and 2) belief that the victim "probably deserved" the violent act by the perpetrator. Many

individuals, including community leaders and parents are aware of these issues, to some degree, but have done little about them. This practice of "turning away" or "not getting involved" is common. Loyalty to extended family and clan contributes to this problem.

Several informants stated that the Navajo family is dominated by the male. When a woman marries a man, she is considered by some to be his property. It is difficult for a woman to leave such a relationship even if it involves family violence. Under these circumstances, the woman often leaves with only "the clothes on her back," a phenomenon that contributes to increasing homelessness on the reservation. An informant stated that some Navajo women are victimized through family violence or abuse as children. Women openly express their feelings of abandonment and hurt, and those feelings are reflected in contemporary women's discourse about Changing Woman traditions and women's reactions to violence. Some women have a difficult time coping due to victimization as children (i.e., as the subjects of rape and sexual abuse). Some women flee to bordertowns and are homeless, due to victimization and a lack of family support. The participants in the area's "alcohol culture" are often childhood victims of abuse or victims of family violence. Contrary to these observation, other informants stated that the traditional Navajo culture is matriarchal. Furthermore, while the woman becomes the "property" of the man, he, likewise becomes the "property" of the woman.

According to many informants, members of the law enforcement division are viewed as being ineffective when dealing with family violence. These informants stated that the law enforcement officials do little of lasting impact concerning the perpetrator. Often the perpetrator is arrested, jailed overnight, or released within a few hours. Many victims live in isolated, rural areas without a telephone or means of transportation. Thus, they have no access to law enforcement authorities, medical care, or shelters. Some informants reported that law enforcement officials are viewed as applying the law unevenly; some individuals and families seen to be unfairly singled out, while the police "look the other way" with other individuals and families. There are known incidents where members of the police force have physically abused or, in some incidents, killed their spouse. Informants indicated that police are unresponsive to calls for help. One informant stated that the Navajo Nation police openly admit (e.g., in an October 1993 oral report to the Navajo Nation Council) that police officers do not want to deal with family violence. The Office of the Prosecutor has been criticized for a statement of prosecution priorities which puts family violence far down the list. It was said that the Navajo Nation jails have a capacity of 85 prisoners nationwide at any given time (and less, given renovations). In the view of some judges, police are not carefully considering the nature of the offense when releasing arrestees. On one occasion, a woman victim of family violence begged a judge to overrule a police decision to release her abusive husband.

The Domestic Abuse Protection Act of 1993 attempts to address policing shortcomings by providing private remedies. This law does not impose duties for police other than advising victims of remedies. The Judicial Branch is attempting to identify family violence in criminal cases to impose conditions of release or sentence, and family court judges suggested that there is a sharp increase in protective order filings.

As in many places in the United States, policing has been ineffective in addressing domestic violence. That is why the Navajo Nation judges are attempting to provide private remedies and use community peacemaking to address the problem. Peacemaking is said to be effective because it gets at denial and involves families in discussions to deal with it.

One informant stressed that it is absurd to recommend training without making additional resources available. This informant stated that the case study would be incomplete without discussion of what happened with the Indian Child Protection and Family Violence Prevention Act of 1990, Public Law 101-630. Although the Act authorizes funding for Indian programs, actual funds were not appropriated to fund local programs. The funding authorizations under the Act expire at the end of FY 1995, and there is no funding for Indian programs as of that fiscal year. The informant stated that it is a farce to recommend training and education programs in light of what happened with the 1990 Act, and the IHS' proposed action plan to deal with family violence and child mistreatment is inadequate.

Several of the informants indicated that external influences such as television, videos, magazines, etc., have a detrimental affect on tribal members, especially the youth. These information sources reinforce behaviors often associated with family violence.

Another problem is the prevention or treatment of family violence is a lack of trained personnel. Many of the professionals are non-Indian and sometimes are not culturally sensitive, which results in conflict with tribal members.

All factors contributing to family violence must be addressed individually, and in concert. The majority of informants indicated that alcohol abuse is a factor in family violence.

Communication is a problem. The vastness of the Navajo Reservation, with many people living in isolated areas, creates communication problems. In addition to the geographical vastness, the Navajo government structure is a complicated bureaucracy that hinders communication. For

example, some of the informants were unaware of the Domestic Violence Prevention Act that was passed during the time of this site visit.

V. RECOMMENDATIONS

Informants were asked for advice and suggestions to prevent or reduce family violence on the reservation. A summary of suggestions is presented below:

A. Training/Education

The recently enacted Domestic Violence Prevention Act mandates a carefully planned training program. This training will require considerable resources, time, and evaluation.

In-Service Training. Periodic in-service training and workshops (3-4 times a year) were recommended for personnel who work with victims of family violence. This training should focus on the dynamics of family violence (aggressive behavior, types of battering) intervention techniques, rehabilitation and recovery from abusive behavior,

School-based Programs. A prevention program for grades K-12 should be implemented. This program should focus on issues related to family violence (i.e., the identification, behaviors, and prevention).

Community-based Programs. Although awareness training is provided by some of the shelters, there is a need for a community-wide education program. This would be a concentrated effort to obtain community support and ownership of a prevention program.

Alcohol/Substance Abuse Treatment Programs. Treatment programs focusing on alcohol and substance abuse should include family violence prevention components. The programs could be located in schools and in the chapters.

Special Training Needs. Special training should be provided for "front line" agencies (i.e., police department, IHS, tribal social services staff, mental health staff, shelter staff, etc.). The training should be offered to all levels of staff within each division. Key staff are often unavailable, and other staff are frequently required to deal with victims during initial contact. These staff should be aware of special needs of the victim as well as the program policies, procedures, and protocols.

B. Strengthen Laws and Law Enforcement Efforts

Informants indicated that efforts in dealing with family violence could be more successful with improved involvement from the police department. In addition, uniform application of laws would engender respect from community members. Quicker response to, and follow through on incidents of family violence are needed.

The Domestic Abuse Protection Act, enacted in July 1993 specifies that the police provide assistance to victims who require restraining orders. Legislation is needed to require better protection of the victim(s) by the police. Once the legislation is passed, training in these procedures, as well as follow-up, will be required for improvement of efforts to prevent family violence on the Navajo Reservation.

C. Coordination of Programs/Agencies

The Navajo Nation government structure is a complex bureaucracy. In addition, there are the Federal requirements inherent in the IHS and BIA programs and services as well as state procedures and protocols in some jurisdictions of the reservation. Multiple and conflicting protocols and procedures cause confusion for the victims of family violence. Sometimes this confusion results in the victim not seeking or receiving needed services and/or assistance.

There is a need for the structure to develop 1) an agreement on the division of labor and responsibility, 2) develop a coordination plan that is reflected in the reporting system, 3) measure and report progress to an interagency group or committee, and 4) commit available resources not fully utilized such as CHRs, alcohol counselors, police, etc.

D. Reporting Systems

The various agencies (tribal, Federal, and state) with programs for addressing family violence each maintain some level of reporting system. Often these systems are agency/division-specific, and most do not include a tracking system for follow-up activities. In addition, data is often manually tabulated, leaving room for errors. There is a need for an accurate reporting system that integrates the various records maintained by each agency or program. Such a system could reduce duplication of efforts, and free up needed resources to focus on other aspects of prevention/intervention of family violence.

As part of the recently enacted Domestic Violence Prevention Act, the Navajo Nation developed an automated system for recording and tracking cases of family violence. Training is currently underway for users of this system. This system has the potential to alleviate duplication of effort, and for meeting the mandated reporting needs of tribal, Federal, and state programs.

E. Return to Traditional Values

Incorporating traditional customs and values, and the intergenerational sharing of values and knowledge can be a supporting and strengthening mechanism in combatting family violence. Family violence prevention efforts incorporating activities expressing cultural values and traditions could be a healing process for individuals, families, and communities.

F. Critique of the Case Study and its Recommendations

Copies of each of the draft case study reports were provided to the point of contact of the participating tribe with a request for corrections and comments. The corrections were incorporated in the final case study reports. One of the reviewers of the Navajo case study report provided extensive comments. A portion of these are provided below.

Why is it, that while the literature clearly shows that Indian country crime rates are far higher than the general American population that nothing has been done to give Indian nations the backup they need to address those rates? Why is it, that as Congress debates crime legislation that it rejects Indian nation suggestions to make their crime-fighting initiatives a priority in funding set asides?

What will be done with the four case studies? I understand that they are the IHS response to the 1990 violence and abuse prevention Act. The five recommendations at pages 22 through 24 are all very fine — they tell us what we know already. Where is the recommendation that the Government of the United States must overcome denial of the effects of its policies? Where is the finding that Indian country family violence is the product of institutionalized violence against Indians in the United States?

Where is the recommendation that the United States must honor its trust responsibility to assure justice in Indian Country to overcome the patterns of violence found in the study?

The National Research Council's 1993 report addresses the comparative merits of quantitative studies of violence and popular reaction reflected in surveys. Both are important. However, the major shortcoming of this report is an inadequate assessment of available data, as limited as it is.

I appreciate the limitations of doing demographic research in a short period of time with limited resources. There are some 1970s studies of Navajo violence which need updating. As the National Research Council concludes, we need longitudinal studies of violence to better understand its causes. The question remains, what is IHS going to do to implement your report and provide the means to do longitudinal studies?

ATTACHMENT 4

ROSEBUD SIOUX CASE STUDY REPORT

A CASE STUDY OF FAMILY VIOLENCE IN FOUR NATIVE AMERICAN COMMUNITIES

ROSEBUD SIOUX TRIBE

I. INTRODUCTION

Support Services International, Inc. (SSI) under contract with the Indian Health Service (IHS) conducted a case study on family violence on American Indian reservations. As part of the study, site visits were conducted to four geographically and culturally diverse Indian communities. The case study sites included the Rosebud Sioux Tribe, the Confederated Tribes of Warm Springs, the Navajo Nation, and the Eastern Band of Cherokee.

The purpose of the site visits was to collect primary and secondary data concerning 1) the prevalence of family violence, 2) the factors perceived to influence family violence, and 3) the intervention/prevention measures in place and/or under consideration. Secondary data were obtained from tribal programs, the IHS, the Bureau of Indian Affairs (BIA), state, and other programs.

This report is a summary of the site visit conducted at the Rosebud Sioux Reservation in South Dakota. It is important to note that while no single reservation or community is representative of any other, the results of this site visit should be of value as a case study of family violence in American Indian communities.

II. METHOD

The four case study sites were selected using the following criteria: 1) geographic and cultural diversity, 2) willingness of the tribe to participate in the study, and 3) availability of relevant data.

Once the tribes agreed to participate, a point of contact was established. Through a joint effort, a site visit protocol and itinerary were developed for on-site data collection.

Data were collected through 1) unstructured interviews with key informants including representatives from tribal, Federal, state, and other programs, and 2) review of secondary data sources. A discussion of each data source is presented below.

A. Unstructured Interviews with Key Informants

Representatives from tribal and other programs focusing on family violence (e.g., social services, mental health, judicial, law enforcement, medical, and education systems) were interviewed. Unstructured interviews were conducted with 22 key informants:

- Karen Artichoker, Director, White Buffalo Calf Woman Society
- Steve Brave, Assistant Director, Rosebud Sioux Ambulance Service
- Carmen Campbell, Outreach Worker, Healthy Start
- Margaret Douville, Director, Child & Family Services
- Cecelia Fast Horse, Counselor, Child & Family Services
- Sharan Freiberg, Service Unit Sanitarian, IHS Hospital
- Winefried Hairy Shirt, Outreach Worker, Healthy Start
- Alex Lunderman, Chairman, Rosebud Sioux Tribe
- Denita Marshall, Clerk of Court, Tribal Court
- Deb (Tsosie) Meek, Environmental Engineer, IHS Hospital
- Scott Melvin, Social Worker, South Dakota Department of Social Services
- Cheryl Prue, Director, Head Start Program
- Sherry Red Owl, Director, Tribal Education
- Ellen Roshone, Quality Assurance Director, IHS Hospital
- Lino Spotted Elk, Director, Rosebud Sioux Ambulance Service
- Nancy Vanderbrake, Director, Public Health Nursing, IHS Hospital
- Lorraine Walking Bull, Data Entry Clerk, Healthy Start
- Anita Whipple, Administrator, Rosebud Sioux Tribe Health Administration, Principal Contact
- Cecil White Hat, Director Rosebud Sioux Alcohol Treatment Program
- Sandy Wilcox, Assistant Director, Healthy Start
- Penny Wilson, Director, Mental Health, IHS Hospital
- Everdale Wright, Director, CHR Program

Discussions with key informants, ranging from 50 to 90 minutes, were conducted over a two-day period in July 8 and 9, 1993. Each informant was interviewed separately by contractor (SSI) staff. After the discussions were completed, the interviewers prepared a summary of the information

collected. An exit interview was conducted with the Health Administrator, and the major issues and questions that emerged from the site visit were presented and discussed. Finally, the draft of this Case Study Report was submitted to the principal tribal contact (the Tribal Health Administrator) for review and feedback. This case study report reflects the feedback obtained from the tribal reviewers.

A variety of documents were collected and reviewed (see Attachment A). The length of the list prohibits inclusion in the body of this report. Sources include tribal, Federal, and state programs.

III. TRIBAL PROFILE

Part of the Lakota Nation¹, the Brule², or the Sicangu Lakota, as they call themselves, are the inhabitants of the Rosebud Sioux Reservation. The Sicangu Lakota are a part of the rich Plains culture characterized in the late nineteenth century as semi-nomadic. The Sicangu social organization was reflective of the Lakota's patterns as a whole; for example, they had a bilateral descent. Due to many intermarriages among bands of Lakota, the children usually had a choice of descent group—the daughters choosing the mother's band, and the sons choosing the father's band. This descent was flexible as a child could choose between the two bands. This system created a flexible matri/patrilocal resident pattern which some have argued kept the bands allied.

During the Plains Indian Wars of the 1860s, better known as Red Cloud's (an Oglala Chief) Wars, the Sicangu Lakota were allied with the other bands of Lakotas as well as with the Northern Cheyennes and the Arapahoes in their struggle to keep their sacred Black Hills from non-Indian intrusion.

After the Plains Indian Wars of the 1860s and the defeat of Colonel Custer, and their surrender at Fort Robinson, Nebraska, the Sicangu Lakota were given a large section of land, along with their allies, under the Fort Laramie Treaty of 1868. This land included portions of the current states of Nebraska, North and South Dakota, Wyoming, Colorado, and Montana. It is within this treaty that the Great Sioux Reservation was formed and the Spotted Tail Agency established. The original reservation was located in Nebraska near Fort Robinson. Subsequently, a permanent site was

Historians have categorized them as the Teton Sioux, Western Sioux, Teton Dakota or Western Dakota, which also includes the Oglala Lakotas of the Pine Ridge Reservation, Mnikowoju Lakotas of the Cheyenne Eagle Butte Reservation, and the Hunkpapa Lakotas of the Standing Rock Reservation, to name a few.

² A French term for the Sicangu Lakota

established along the Rosebud Creek in what is now South Dakota. This reservation later became known as the Rosebud Sioux Reservation.

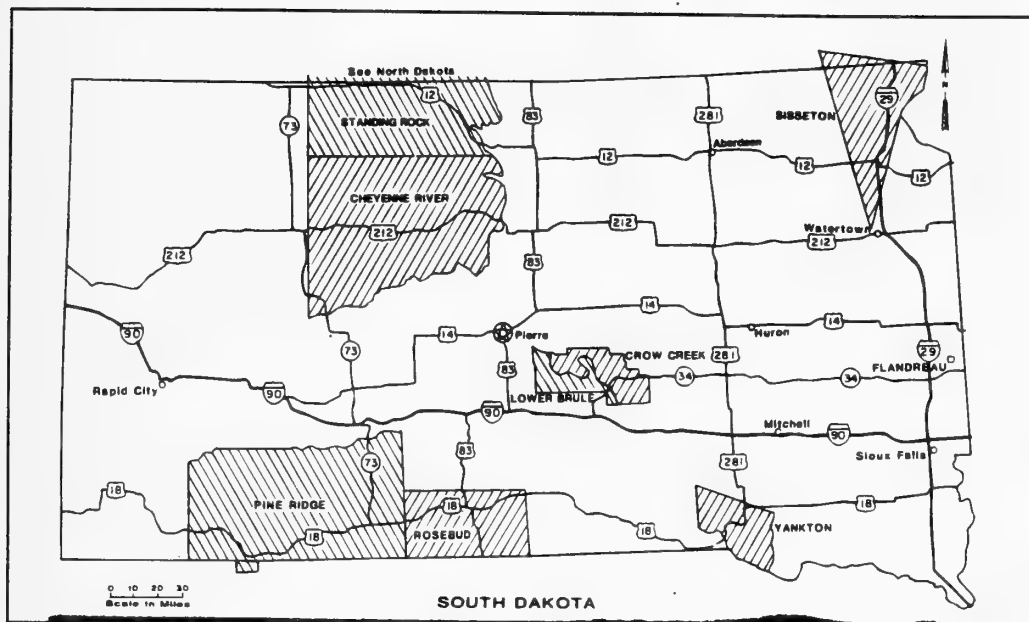


Figure 1. Location of Rosebud Reservation

The Rosebud Sioux Reservation is located in South Dakota, about 200 miles from any major city in any direction (see Figure 1). It includes the four counties of Todd, Tripp, Mellette, and Gregory as well as parts of Lyman County. The largest Indian population, including the Sicangu Sioux and members from other tribes, is concentrated in Todd County. The land area of the Rosebud Sioux Reservation is approximately 5,337 square miles. The tribal headquarters are located in the town of Rosebud. There are 21 tribal communities within the reservation boundaries (see Table 1).

TABLE I: Tribal Communities within Rosebud Sioux Reservation

1. Antelope	7. Grass Mountain	13. Parmalee	19. Swift Bear
2. Bad Nation	8. He Dog	14. Ring Thunder	20. Two Strike
3. Black Pipe	9. Horse Creek	15. Rosebud	21. Upper Cut Meat
4. Bull Creek	10. Ideal	16. St. Francis	
5. Butte Creek	11. Milk's Camp	17. Soldier Creek	
6. Corn Creek	12. Okreek	18. Spring Creek	

According to the latest figures obtained from the BIA 1991 "Report on Service Population and Labor Force," there is a total of 13,050 Indians living within the Rosebud Reservation borders, and 1,772 that live adjacent to the reservation. There are 4,099 children under the age of 16, and 2,215 between the ages 16-24 who reside on the reservation. The potential labor force is 8,033; however, actual employment is reported as 852 resulting in an unemployment rate of 89 percent. There are 570 employed individuals earning \$7,000 dollars or more a year and 282 earning less. Women comprise slightly more than half (450) the workforce.

The religion of the Sicangus and the Lakotas, as a whole, is represented and influenced by the acculturation and assimilation processes endured during the early reservation period. During this time, many different Christian denominations were brought to the reservation and attempts were made to convert the Lakotas to Christianity. This general policy was followed by the Federal Government in their dealings with the American Indians. Consequently, the Rosebud Indian Reservation comprises many factions, with various Christian denominations competing for membership as well as retainment.

With the initiation of President Grant's Peace Policy in 1869, large numbers of Christians came to live and proselytize on the reservations. It was not until years later that the Indians were able to practice their traditional religion more openly. This policy bred confusion that still persists today with Christian ideologies and traditional Lakota religion. Even with tremendous cultural change, the traditional Lakota religion still survives today. Although some aspects have been lost, many of the old values are still part of contemporary Lakota religion.

Traditionally Lakota children were granted exceptionally wide latitude in behavior up to the age of about 7 years. Prior to that age, violence directed toward Lakota children was virtually taboo and unknown. After that age, corporal punishment was still rare. Much of the socialization of children was the responsibility of the paternal uncle.

A. Government

The Tribal Council of the Rosebud Sioux Indians was created with the introduction of the three-fourth's majority clause, which was part of the Fort Laramie Treaty of 1868. This clause was designed to protect the rights of small bands of Sioux. The three-fourths majority concept basically eradicated the "chief" concept of the Sioux tribes; however, these concepts were not enforced and implemented prior to the Great Sioux Agreement of 1889. The Great Sioux Agreement was part of the Dawes General Allotment Act of 1887. This Act basically restructured Indian lands by allotting

one-quarter section of land to each individual head of a family. Additionally, one-eighth of a section of land was allotted to each single person over 18 years of age. After these allotments were made, a surplus of land remained which was dispersed to homesteaders.

The Dawes Act required signatures of three-fourths of the Sioux male population for implementation. Subsequently, all Sioux decisions were made in this manner. In 1911, the Indian Affairs Superintendent for the Rosebud Sioux Tribe declared that the three-fourths concept of governing was impractical. He established a representative council called the Business Committee with 20 members from various farm districts, band camps, and day schools. He also established constitutions for the Business Committee.

In 1934, the Indian Reorganization Act, known as the "Indian New Deal," was passed. Subsequently, a new Commissioner of Indian Affairs, John Collier, was appointed as the Secretary of Interior to promulgate this new policy to the Indians and to help reform Indian policy. The Franklin D. Roosevelt Administration proposed a more tribally-controlled reservation that decreased interference in tribal affairs by the Office of Indian Affairs (OIA). Consequently, a tribally-controlled government came into existence. This included a governing body consisting of a council known as the Rosebud Sioux Tribal Council. The Council consists of one representative, elected for a 2-year term, from each of the 21 communities on the reservation. The administrative offices of President and Vice President were established. These 2 offices are elected at large for two-year terms.

B. Judicial System

The judicial system, in conjunction with the Rosebud Tribal Council, recognizes that family violence is a serious crime not only within the individual families involved, but also with society in general. It is recognized that the only protection some victims have is with the law and those who enforce it. The tribe has a domestic violence code and a child protection code. The following is a summary of the definitions of Domestic Abuse as drafted by the Rosebud Sioux Tribal Council in their Tribal Codes 5-30-2.

The crime of domestic abuse on the Rosebud Reservation is considered a class "A" crime and is defined in the Tribal ordinances as a person who purposely or knowingly causes bodily injury to a family or household member or purposely and knowingly causes apprehension of bodily injury to a family or household member. It is recognized by the Tribal Council that domestic violence will not be tolerated even when alcohol is a factor. In addition, the Tribal Council and the tribal police department will treat all criminals without regard to whether the persons involved are

relatives or family members of the arresting officer or any tribal personnel. Finally, the Rosebud Tribal Council will protect the elders in accordance with the traditions of the tribe.

The Judicial System is administered by the Rosebud Tribal Court. Although busy schedules prevented tribal judges (prosecutors and defense lawyers) from serving as informants for the study, a report titled "A Report of the Prosecutors Office" was provided by the Chief Clerk of Courts. This report relies on police reports for the months of January, February, and March 1993, and includes arraignment data on three types of crimes designated as "A," "B," or "C" crimes. Included in the "A" crimes are domestic abuse, elderly abuse, child neglect, and child abuse.

C. Law Enforcement

The Law Enforcement Division was operated by the BIA until March 5, 1993. After this date, a newly contracted Police Department under the direction of the Rosebud Sioux Tribal Council assumed their duties. The Police Department staff were unavailable for interviews when this site visit was conducted. However, information was provided by the Clerk of Courts concerning the policies and procedures of the police department regarding domestic abuse. These policies and procedures contain the statement of purpose, sections on definitions, crime of domestic abuse, mandatory arrest, 12 hour hold, filing of complaints, liability of law enforcement officers, notice of rights, written report penalties and reporting statistics. The statistics reports are made by tribal police officers on a regular basis and are available to appropriate agencies and the public. A summary of the Rosebud Sioux Tribal codes and ordinances regarding the role of tribal police in dealing with domestic violence is presented below.

The responsibilities of the arresting officers regarding liabilities, protection, and reporting are covered in the Tribal Police Ordinances 5-38-2 addressing Domestic Violence. Section 3, under Mandatory Arrest, states that:

...the police officer shall arrest a person anywhere, with or without a warrant, including at the person's residence, if the officer has probable cause to believe (1) that an assault has occurred, (2) that an assault has occurred with or without observable bodily injuries to the victim, or (3) that any physical action that occurred was intended to cause another person reasonable fear that imminent serious bodily injury or death if the victim is the person's family member, household member or former household member. If both parties have assaulted one another, the officer is not required to arrest both parties but will arrest the aggressor. In doing this, the police officer will take into account all reasonable considerations protecting the victims of domestic abuse, will determine the comparative extent of the injuries inflicted, and

if there is a fear of physical injury will take into account the history of domestic abuse between the persons involved.

Section 4 states that if a person is arrested "he or she will be held without bail for a mandatory 12 hours." The remaining sections of the ordinances refer to the fine and imprisonment of a convicted perpetrator, liabilities of the arresting officer, the social services available to the victim and notice of her/his legal rights. These notices include an order restraining the abuser from further acts of abuse, an order directing the abuser to leave the household, and an order preventing the abuser from entering the residence, school or place of business, an order awarding the custody or visitation with any minor children, and an order directing the abuser to pay support to the victim and minor children where appropriate.

Although the crime of family violence is addressed adequately in the tribal ordinances, applying and enforcing the tribal law to suspected perpetrators is another concern. The transition from a BIA to a tribal police force resulted in the arresting officers being reassigned to different reservations, with the resulting dismissal of some of the cases under investigation. According to a report from the prosecutor's office for the months of January, February, and March 1993, 50 percent of the pending family violence cases were dismissed, primarily because of the unavailability of the arresting officer.

The Major Crimes Act was passed in March 1885 pursuant to conflict between two members of the Indian community (Spotted Tail was killed by Crow Dog). This Act was passed because the murderer was freed because the Federal Courts had no jurisdiction in Indian country. In the Act, Congress identified seven major crimes that would fall exclusively into the hands of the Federal courts: murder, manslaughter, rape, assault with the intent to kill, arson, burglary, and larceny.

The Indian Crimes Act of 1976, Section 1153, title 18, United States Code, defined a number of felonies including "kidnapping, carnal knowledge of any female, not the accused's wife, who has not attained the age of sixteen, assault with intent to commit rape, incest, assault to commit murder, assault with a dangerous weapon, assault resulting in serious bodily injury, and robbery."

In addition to enforcement problems, there seems to be a problem with the quality of written police reports. The inadequate quality of the reports hinders prosecution efforts. Officer transfers and inadequate reports contributed to the dismissal of 87 cases. Most of the cases dismissed involved driving under the influence, assaults on officers, and minor traffic violations. Dismissal of these cases could reflect negatively on the ability of the police department to prosecute more serious cases. The statistics for the months of January, February, and March 1993 show that no "guilty" verdicts

were handed down in the cases of domestic abuse (elderly abuse, child neglect, and child abuse) despite the fact that at least one case in each category was reported during each of these months.

Despite repeated attempts by interviewers, no official of the Rosebud Police Department was available to participate in the study. In the context of the participation by many other tribal agencies and groups, the failure of the police department to participate seemed to be intentional.

D. Social Services

The South Dakota Department of Social Services (SDDSS) - Child Protection Team and the Rosebud Sioux Tribal Police Department, in conjunction with various agencies in and around the Rosebud Reservation, have a system for referring victims of family violence to appropriate agencies. The referral process is coordinated with tribal, state, and Federal law enforcement agencies. In extreme cases, the tribal police officer can take custody of the child and turn the child over to the SDDSS-Child Protection Team for placement and investigation. The SDDSS does not do the initial investigation but does conduct an intake evaluation of the family and conducts an investigation if deemed appropriate.

During the initial intake, anonymity is stressed due to repercussions with the abuser and the abuser's "tiospaye"³ family. Many of the cases include serious physical and sexual abuse and neglect; however, exact figures were not available. The staff of the Tribal Social Services Division is comprised of three social service aides (all Indian), three case managers (investigators), three supervisors, and one home-based worker. One of the shortfalls mentioned by the SDDSS informant was the need for better cross-cultural training for state social workers as well as a need for additional personnel. Because of the large unmet need for services, the services provided seem to be ineffective.

E. Health Services

The Rosebud IHS Hospital, located in Rosebud, SD, serves the health needs of the reservation, and provides various community outreach programs.

The IHS Hospital has guidelines for referrals of child abuse and neglect cases. The IHS Mental Health/Social Services actual cases, as well as suspected cases, should be reported to the South

³Tiospaye refers to "all the relations" concept of family. It can result in a situation where potential witnesses are pressured to renounce their testimony, in cases involving domestic violence, because they are either related to the offender or know someone who is

Dakota Department of Social Services. Referrals are also taken by the tribal police in accordance within the law. Proper procedures for referring child abuse and neglect cases are as follows: In non-emergency cases, the IHS Mental Health/Social Services staff can phone the SDDSS staff person or mail a referral with information regarding the neglected or abused child. In emergency cases, it is important that the tribal police be present at the time of the initial intake or during the emergency medical evaluation. After the police have taken custody of the child, he/she is then turned over to the SDDSS case worker for evaluation and placement. The case worker completes and returns the suicide surveillance data to the Aberdeen Area Mental Health Department within 24 hours after the event.

The Tribal Health Administrator described social problems including domestic violence, alcoholism, and crime; a complex interwoven set of related factors was described. Grief, apathy, and alcoholism were identified as factors related to the existing social problems. In addition, loss of tribal identity, loss of land, the aging process, and family structure were cited as factors in understanding the social problems within the Rosebud Reservation. It was felt that there is a need for intervention and prevention measures for dealing with anger; at this stage alcohol and drugs are used by young people as maladaptive mechanisms. One of the alternative coping mechanisms identified included sports; however since there are only a selected few who can play sports, there is a need for more activities for young people.

F. Education

The Tribe operates a Head Start Program in Mission, South Dakota, and through charters operates a K-12 grade grant school and a tribally controlled college. About 90 percent of elementary and secondary Indian students attend state public schools in the Winner School District and the White River School District both adjacent to the reservation.

The Tribal Code of Education and the State of the Reservation Education Report for the school years 1990-1991 and 1991-1992 outline the tribal education policies and procedures. These documents also contain statistics on enrollment, age, sex, tribal affiliation/enrollment, race, and drop-out rates. There was no available information regarding the causes and effects of the students dropping out of school.

The tribal school system is governed by the Tribal Council which employs a director to oversee the Tribal Education Department. The Tribal Education Code of Policies and Programs (Section 104) contains guidelines on alcohol, nicotine or tobacco, and drug abuse education which the Tribal

Council developed and applied to local schools under the joint enforcement of state and Federal agencies.

The Rosebud Head Start Program was started in 1965 to help low income families develop a firm foundation for the education of children. The Head Start Program offers a nutrition component as part of the holistic program that fits the needs of the family and their children. During the initial screening of the child for the elementary school, held in June of each year, referrals are made to the appropriate agencies if any health anomalies are detected. Parental participation in this process is greatly encouraged for better awareness in early health education. The Head Start Program's policy calls for reporting of potential family violence-child abuse victims to the South Dakota Department of Social Services (SDDSS). Once a case is brought to the attention of the SDDSS staff, a report is made and the involvement of the Head Start Program ends. These procedures are implemented for the protection of the child as well as to limit any potential liabilities to the Head Start Program.

In 1992, the Winner School District operated nine rural schools with an enrollment of 33 students or less. The District also operated an elementary school, a middle school, and a high school in the city of Winner, SD. The American Indian enrollment at all the Winner and elementary schools was 111 (23 percent of the total enrollment) with no drop-outs. The American Indian enrollment at all Winner middle and high schools was 94, with two drop-outs for middle school and 6 drop-outs for high school, respectively. The report did not address factors causing drop-out; therefore, there is not a clear picture of this problem in regard to family violence.

G. Other Programs/Services

The White Buffalo Calf Woman Society, Inc (WBCWS). Founded in 1977, this non-profit organization originated as a forum for women to share their feelings and to propose areas of change. Located in Mission, South Dakota, the shelter functions as a temporary home for women and their families seeking sanctuary from abusive husbands and/or families. A variety of services are provided through the shelter including a 24-hour crisis hotline, workshops, and training sessions for agencies and individuals to promote education and awareness. Since its inception, the shelter has helped over 1,000 women and 2,000 children find shelter and transitional housing.

The Director of the WBCWS emphasized that the problem of family violence has complex dynamics that include economic dislocation, repression of traditional culture, religion and language associated with military occupation, colonization, and anti-Indian racism. For example, traditionally the tribal circle is supposed to be cooperative; however, these complex dynamics contribute to polarization

between some of the social service agencies and tribal members, between mixed bloods and full bloods, between Christians and traditionalists, as well as among the human service agencies.

Another problem for the shelter is an increased population of "drop-ins." This places added demands on the limited resources of the shelter and affects its ability to provide adequate services to victims and their families. There is a need for transitional housing.

The director of WBCWS emphasized a need for both research and technical assistance to help the community address family violence. There is a known need for more shelter space, children's programs and services, teenage women's programs, and peer training. More information is needed in regard to frequency of calls for assistance related to family violence and abuse.

The Little Hoop Lodge. This is a tribally-operated alcoholism program located in Antelope, South Dakota. It was established 22 years ago to assist alcoholics and their families. It is an inpatient program with stays as long as 5 weeks. There is an outpatient program available for aftercare service for patients in need. The treatment referral process is linked with the tribal police, Rosebud IHS Hospital, South Dakota Department of Social Services, resources in adjacent reservations, and other human service agencies in and around the reservation. Thirty to forty percent of the patients referred to The Little Hoop Lodge are from the Rosebud Reservation.

The Director of the Little Hoop Lodge noted that some patients have a history of violence toward family members and spouses unrelated to alcohol abuse. Staff from the WBCWS coordinate services and presentations on family violence on a regular basis for intervention/prevention purposes at Little Hoop Lodge.

One of the problems encountered by Little Hoop Lodge staff is that of the "sleepers" or "overnighters." These individuals are jailed because of alcohol-related infractions, usually public intoxication. Informants indicated that, after spending the night in jail, "sleepers" are released by law enforcement personnel without treatment referrals. The informants indicated that "sleepers" could benefit from the alcoholic treatment services provided by Little Hoop Lodge, and should be referred there.

The Little Hoop Lodge operates a youth camp that teaches children about history, cultural values, and alcohol awareness. Approximately 250 children have attended the camp since its inception.

Watchful Home. Located in Mission, South Dakota, this is a women's shelter operated by the Episcopal Church. At the time of the site visit, no one was using the shelter. The owners of the

shelter were unavailable for discussion; however, a tour of the facility was conducted. Informants suggested that victims of family violence prefer other shelters perceived to be more compatible and friendly to Lakota culture.

Owl Feather War Bonnet Women's Resource Center (WRC). Located in the St. Francis District of the Rosebud Reservation, WRC was formed by the women of St. Francis (formerly Owl Feather War Bonnet Village) to address major social problems (such as poverty, racism, violence, political oppression, and sexual discrimination) affecting Indian people. The Center serves as a resource for Lakota women and their families to answer questions on services available; to provide counseling to women and children in need; and to provide workshops in the community on such issues as health, family relationships, childrearing, culture, and Lakota spirituality.

Spotted Tail Crisis Intervention Center. This center was established in 1986 and serves as a shelter or home for children who have been referred by state or tribal social services. The center serves children from infancy to 12 years of age who have been abused and/or neglected. The Center also serves children 10-18 years of age who are either runaways or homeless. The Center operates under a "638" contract, and receives reimbursements from state and tribal social services as well as private and foundation funding.

Elderly and Child Protection Teams. Since the implementation of the Indian Child Welfare Act in the late 1970s, there has been a functioning child protection team (CPT) on the Rosebud Reservation. Team members consist of representatives from tribal and state social services, IHS Mental Health, IHS Maternal and Child Health, law enforcement, tribal courts, and the schools. CPT members meet on a monthly basis to track where children are in the system. An elder protection team has recently been established to address elder abuse issues. Members of this team were not available for discussions during the site visit.

IV. FINDINGS

Detailed statistics were not available regarding the prevalence of family violence on the Rosebud Sioux Reservation. The majority of the informants, however, indicated that family violence is a big problem on the Rosebud Reservation.

A. Prevalence of Violence

The informants were asked to rate the severity of general violence as well as family violence. Figure 2 presents the a comparison of these two problems. Although the numbers of informants are small (22) and thus may not reflect statistically reliable data, their judgments provide valuable qualitative assessments for the study.

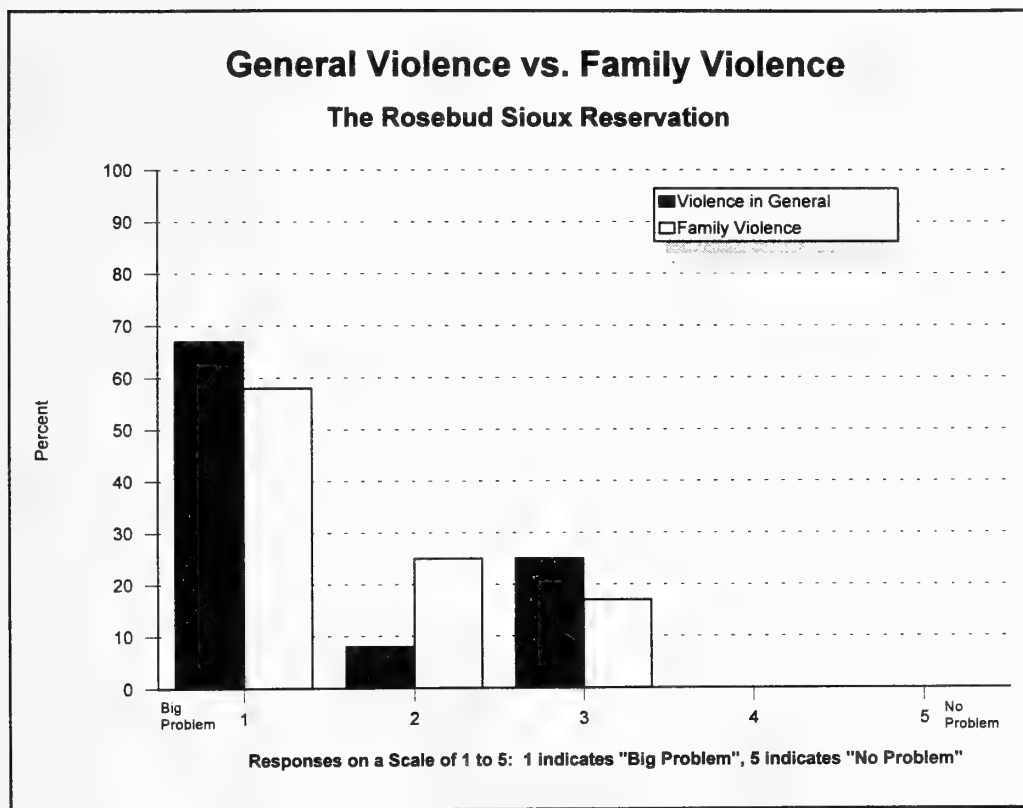


Figure 2. General Violence vs. Family Violence (Rosebud Sioux Reservation)

The majority of informants indicated that violence in general (66r percent) and family violence (58 percent) in particular are a "big problem" on the reservation. No informant judged violence in general or family violence to be a "small problem" or "no problem."

Violence in General. Over 30 percent of the informants judged assaults (with and without a weapon), suicide, and gangs to be a "big problem" on the reservation (see Figure 3).

Family Violence. Fifty percent or more of the informants reported wife abuse, child abuse, and child sexual abuse to be a "big problem" on the reservation. In general, husband abuse was judged to be a relatively minor problem. Elder abuse was judged to be slightly less of a problem than wife and child abuse (see Figure 4).

Informants stated that elder abuse includes "dumping" (a situation in which parents "dump" their children on their parents). Elderly people with limited food and money are often compelled to care for their grandchildren. Often the elderly people need care themselves, and lack the resources and strength required to care for children.

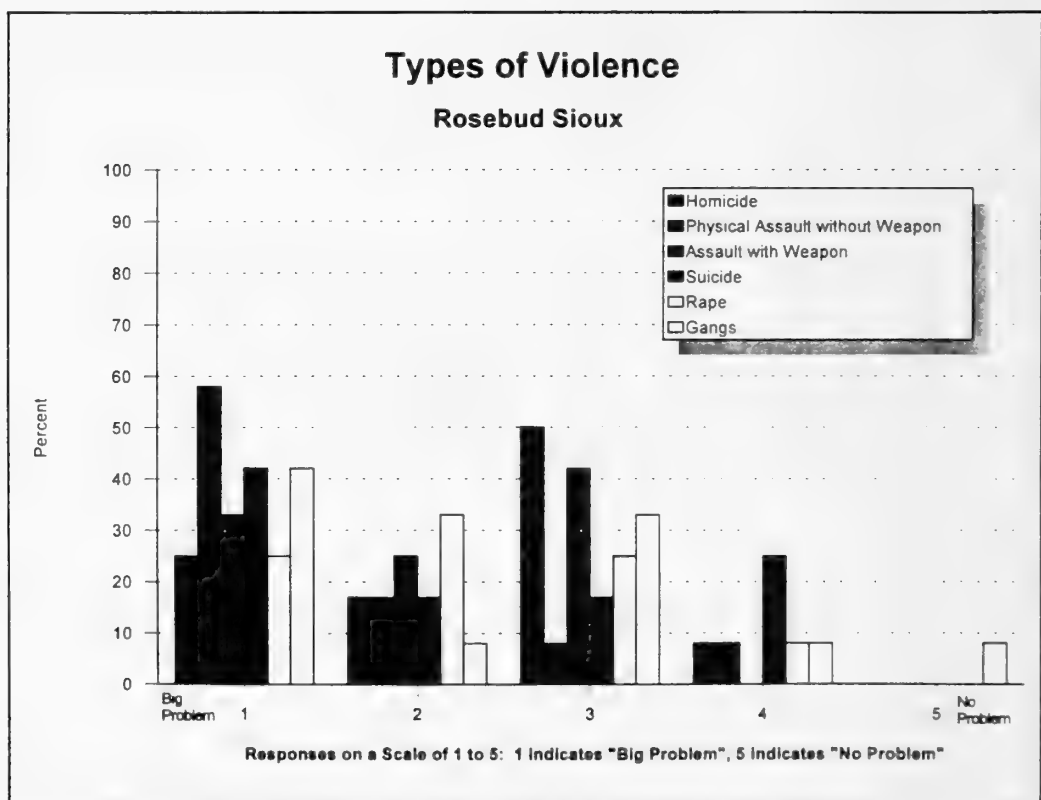


Figure 3. Judgments of the Types of Violence on the Rosebud Sioux Reservation

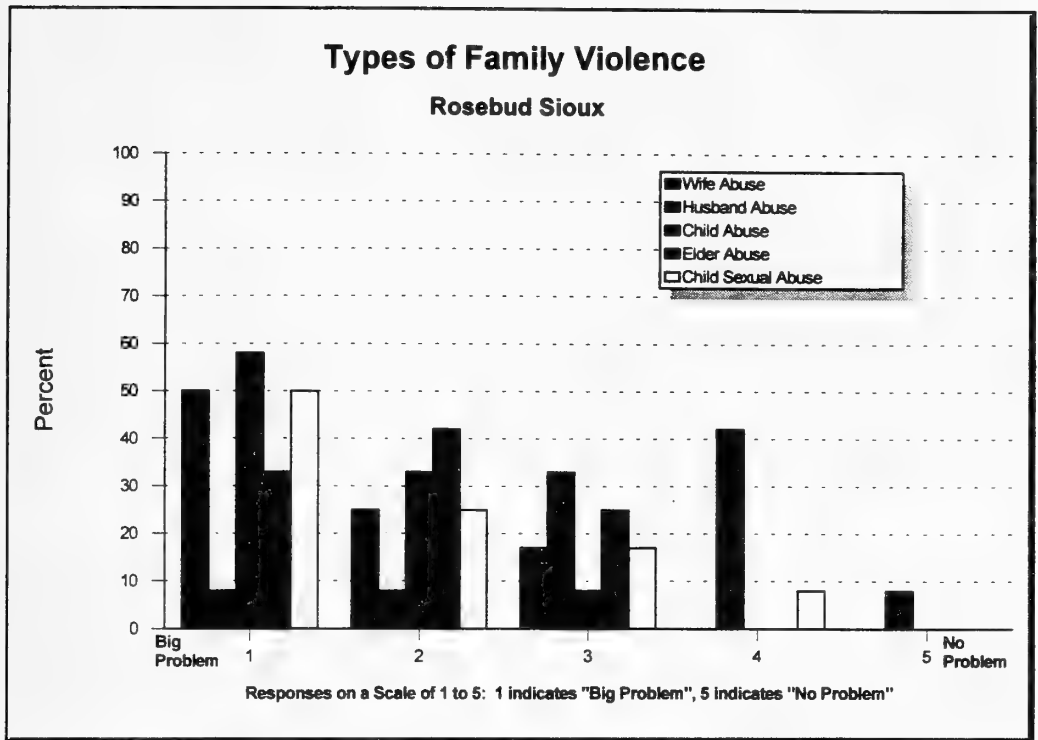


Figure 4. Types of Family Violence on the Rosebud Sioux Reservation

A number of informants stated that people were quick to rationalize violent behavior; for example, if a man beat his wife, people concluded that she probably deserved it. Violence in the community was characterized as a means of resolving disputes. Many members of the reservation see and nearly always know which families are affected by violence. Many cases involve serious physical and sexual abuse. Most respondents agreed that if they could change public or community perceptions and values about violence, half the battle would be won.

Most informants indicated that they deal with domestic violence on their job, in some capacity, on a regular basis. Examples include coworkers who are experiencing family violence, staff shortages associated with absences due to violence, victims in school, and through the provision of medical care. Exposure to family violence is related to the nature of the job held by the informants. Health care providers, mental health and social service staff experience family violence more frequently.

While most of the informants indicated that family violence is a big problem on the Rosebud Reservation, there was a sense that it is the symptom of a much larger, complex problem. The problem was viewed as involving the complex effects associated with the destruction or repression of the traditional Lakota way of life including language, religion, economy, kinship system, and government resulting in poverty, unemployment, economic and social dysfunction, and alcohol abuse.

B. Programs/Services

Informants varied in their knowledge and familiarity with intervention/prevention efforts to address family violence on the reservation. Most were aware of shelters and education/awareness programs. As shown in Table 1, most informants rated these resources as moderately inadequate, with limited accessibility.

Table 1. Availability and Accessibility of Resources for Victims of Domestic Violence

	1	2	3	4	5
Availability*	0%	8%	67%	25%	0%
Accessibility**	0%	0%	58%	42%	0%
* 1=Excellent, 5=Non-existent					
** 1=Easy Access, 5=No Access					

1. Programs/Services in Operation

The programs and services available to victims of family violence include shelters for women and children, alcohol treatment programs, support groups (for women and men), youth camp (based on a cultural awareness curriculum), women resource center (a "think tank" for women and elders), and crisis intervention centers. Although a variety of services are provided including refuge, education, counseling, alcohol treatment, all informants indicated there is a critical need for additional programs.

Most informants were aware of the existence of the shelters; however, they expressed a need for more prevention efforts. Many rated the shelters as being moderately to fairly unsuccessful in dealing with family violence. All of them mentioned the need for more services for young people who are the victims of family violence.

Referral Systems. The Tribe, in conjunction with the SDDSS CPT, and other agencies in and around the reservation have a system for referring victims of family violence to appropriate agencies. Most informants indicated that they make referrals to various agencies (shelters, IHS Mental Health services, and tribal and state social services). However there appeared to be little in place in terms of tracking systems. There is a lack of systematic follow-up in most cases.

Tribal Ordinances. The Rosebud Tribe has developed ordinances clarifying the tribe's position on family violence. Family violence is viewed as a crime, and the ordinances specify procedures for handling perpetrators. Nevertheless, many informants indicated that there was a sense that the tribal police are more lenient than they should be in handling many family violence cases. In addition, many cases involving family violence are dismissed by the courts. Two factors contribute to this problem: 1) written police reports often do not "hold up" in court; and 2) "tiospaye" where tribal members are reluctant to testify against a member of their family or a friend of their family.

2. Additional Programs/Services Needed

Despite the available resources, all informants stated that additional programs and services for the prevention of family violence are needed (see Table 2). In addition, they rated the existing services as being inadequate.

Table 2. Efforts to Prevent Family Violence on the Reservation

	1	2	3	4	5	N/R
Needed*	75%	17%	8%	—	—	—
Successful**	—	8%	17%	33%	33%	8%
* 1=Needed, 5=Not Needed						
** 1=Easy Access, 5=No Access						

Education/Awareness Programs. Most informants are aware of some educational efforts in place concerning the intervention/prevention of family violence on the reservation. However, there is a consensus of a far greater need for educational programs beyond what exists. It was felt that an education program on issues related to family violence should span all K-12 grades in the schools. A community-based educational program focusing on family violence is needed for the reservation.

There is a critical need for programs for teens and youth. There are very few youth programs available which contributes to family violence incidents, according to a number of informants.

C. Difficulties in Addressing Family Violence

Despite the existence of shelters and other resources for dealing with family violence, the problem persists. There was a sense among informants that until the roots of the problem are addressed, family violence is not likely to go away. Several informants indicated there is a definite relationship among alcohol, oppression, family violence, and the overall living conditions on the reservation. There are very few jobs on the reservation and the unemployment rate is 89 percent. The tribal members that are employed work for either tribal government programs, state sponsored programs, or Federal agencies/programs. The lack of employment causes a general attitude of despair for most tribal members.

The capability of the tribe to oversee and identify issues related to family violence is one of resources and priority. For instance, the Rosebud Child and Family Services meets with potential victims of abuse and violence; however, it is the aftercare and follow-up procedures that are lacking. This lack is a result of heavy case loads, and the shortage of resources and staffing. To address these shortages, many tribes have networked with outside agencies. Unfortunately, the staff of such agencies are frequently non-Indian and are unfamiliar with the Lakota culture. This creates conflict as to how to best address family violence on the reservation.

The roles of men in contemporary "Sioux society" are vague. In the "old days," the male was the protector and provider of the nation. Male roles were clearly defined. Some of the men were holy men, "medicine men," and policemen (akicita). The latter meaning that they were used to make society work, and to keep the nation's social aspects functioning properly. In today's society, the male role is not clearly defined. Many of today's "Sioux males" are without positive role models and father figures. This has been occurring for several generations and, as a result, year after year, more and more children are growing up without male role models, or even males in the home. Many families are headed by women; fathers are often absent from the household.

A comment heard repeatedly during the site visit to Rosebud, was regarding the "Sioux male." While the women were more willing to come in for treatment and counseling, men remained distant. While there were shelters and support groups for women, there were no services exclusively for men.

A typical scenario, one informant suggested, was where a young female feels the love of a young male. Even though the young male is violent, the love that the female feels is sometimes the only feeling of love she has had in all her life. He, on the other hand, witnessed his father hit his mother and learned that his may be proper in that environment.

One informant stated that family violence often involves drinking and partying, while the children are left unattended. She also mentioned that there are increased incidents of gang activity and formation of satanic groups, especially among 7th to 9th graders.

Many informants stated that they view the law enforcement personnel as lagging woefully behind other tribal departments in addressing violence in the community and in the home.

Another factor is "tiospaye." Tiospaye encompasses the relation of family members, producing a situation where family members are reluctant to testify as witnesses in family violence cases. Thus, family members and other potential witnesses are pressured to renounce their testimony because they are either directly related to the person or know someone close who is.

V. RECOMMENDATIONS

Many of the suggestions received for addressing family violence involve the increase of resources, financial as well as human. They are discussed below.

A. Training/Education

In-service Training. Training is needed for both law enforcement and medical personnel including Community Health Representatives (CHRs) and Emergency Medical Technicians (EMTs). Both groups are often early responders in family and community violence situations. The outcome of the situation depends on how well they respond, how knowledgeable they are (degree of training in family violence issues), and their personal experiences with issues related to family violence. Training should include topics such as dynamics of family violence, intervention techniques, reporting requirement and follow-up procedures, roles and responsibilities of other primary responders.

School-based Programs. A prevention program should be developed for grades K-12 which focuses on issues related to the dynamics of family violence including identification, causes, and prevention.

Communication/Outreach. Through use of mass media or other options, communicate information on programs and services available for dealing with family violence. Provide information to the general public on the dynamics of abuse (child, spouse, elderly, community). Provide outreach to potential victims and abuses, and promote community awareness at all levels.

Men's Groups. There is a need for support groups for men to help them understand the battered wife syndrome and related issues. Other topics should include learning emotional communication and sharing. These support groups should be conducted by culturally-sensitive counselors. Such treatment should be mandated by courts for perpetrators found to be guilty.

Family Counseling. Programs focusing on healing and educating the whole family are needed. This should be a coordinated approach involving social services, CPTs, shelters, mental health., etc. The safety of the victim(s) is of utmost concern; care should be taken to obtain treatment for the perpetrator before attempts are made to reunite the family.

B. Coordination of Programs/Services

Just as every member of a family contributes to the family health status, every department, program or service in a community contributes to how well the community functions. Tribal, Federal, and state agencies have protocols and procedures for dealing with family violence. Multi and conflicting protocols and procedures can result in confusion for the providers and the users of services. Interagency agreements clearly specifying roles and responsibilities, and reporting requirements, are needed to further aid in the prevention of family violence.

Law enforcement is viewed as the weak link in primary responders to domestic violence. Training of police officers is recommended. Interdisciplinary training, where the interrelated roles of primary responders are reviewed (e.g., police reports are an integral part of prosecution of perpetrators) is needed.

C. Reporting Systems

The various agencies (tribal, Federal, and state) with programs for addressing family violence generally maintain some type of reporting system. Oftentimes, these systems are agency-specific, and most do not include a tracking system for follow-up activities. In addition, data is often manually tabulated, making data integration and sharing difficult. There is a need for an accurate reporting system that integrates the various records maintained by various agencies or programs. Such a system could identify areas of duplication, and help build a database useful for all agencies. In addition, it would prevent situations where victims "fall through the cracks."

D. Youth Services

There is a critical need for youth and teen programs. These programs and activities should include cultural awareness activities. A return to traditional values and practices including intergenerational sharing of values and more support from community leaders is viewed as critical in the prevention of family violence.

ATTACHMENT A

LIST OF SECONDARY DATA

Pamphlets

NOVA: National Organization for Victim Assistance

- "Crime Victims and Chronic Trauma"
- "Crisis"
- "The Co-Victims"

Rural America Initiatives

- "Dakota Transitional Head Start"
- Owl Feather War Bonnet — Women's Resource Center
- White Buffalo Calf Woman Society, Inc.
- National Coalition Against Domestic Violence
- Rosebud Sioux Head Start

Native American Women's Health Education Resource Center

- The Rosebud Project

Home Base Family Services Program: Southern Plains Mental Health Program

- Date Rape by the South Dakota Coalition Against Domestic Violence and Sexual Assault
- Give Your Child a Head Start, U.S.D. M.M.S.
- Facts about Rape by the South Dakota Coalition Against Domestic Violence and Sexual Assault
- A Handbook on Child Sexual Abuse by South Dakota Coalition Against Domestic Violence and Sexual Assault
- The Rosebud Sioux Tribe: Code of Education
- The Rosebud Sioux Tribe: Second Annual State of Reservation Education
- Rosebud Sioux Labor Force Report 1992

Judicial Law: Codes and Regulations (terms)

- Elder Abuse (5-37-1)
- Domestic Abuse (5-30-2)
- Report from the Prosecutor's Office for the months of January, February, and March 1993

R.S.I. Alcohol Treatment Program

- Program Narratives and Statistics
- A.A. Recovery Scheduled Meetings

570 and Aftercare Task Force Report

Social Services Intake Worksheet (child abuse)

Medical Health Services

- Rosebud Service Unit Inquiry Prevention Program Plan
- Aberdeen Area IHS Suicide Surveillance (intake worksheet)

ATTACHMENT 5

ANNOTATED BIBLIOGRAPHY

ANNOTATED BIBLIOGRAPHY

PAMPHLETS

The Battered Woman, The American College of Obstetricians and Gynecologists, Technical Bulletin. An Educational Aid to Obstetrician-Gynecologists, Number 124, January 1989.

This bulletin identifies and defines the battered woman and the battered wife syndrome as well as the physical abuse that goes along with it. It also provides statistics on the frequency of the incident and the public health impact it may have. It makes a case for spousal abuse to child abuse. The purpose of this manual also is to identify characteristics needed to identify physical abuse for the health professionals, obstetricians and gynecologists, since they are the primary care providers for many women.

Suicide Among American Indian Youth, Youth 2000: A Special Report

This paper focuses on suicide in Indian Country. It demarcates and delineates some of the issues that surround the Indian youth and offers statistics on suicide rates. The author has recognized some general characteristics after a review of the literature; Indian suicide in most tribes occurs predominately among males; Indians generally use highly lethal or violent methods (guns and hanging) to commit suicide; tribes with loose social integration emphasizing a high degree of individuality generally have higher cetyl rates than those with tight integration; tribes who are undergoing rapid change in their social and economic conditions have higher rates than those that are not.

CONFERENCE PAPERS

Pagelow, Mildred Pagelow. 1987. Application of Spouse Abuse Research to Policy. Fullerton, California State University. *Third National Family Violence Conference*, 7 July.

This paper presents recommendations supported by research findings for the prevention and intervention of spouse abuse.

Elisoff, Theresa. 1991. The Child's Spirit: A Leadership Conference. Colville Reservation, Washington. *Child's Spirit Planning Committee Resource Guide, Confederated Tribes of The Colville Reservation*, 8 August.

This resource guide was conceived from ideas generated at the referenced conference.

Abrams, Lew, Ph.D. 1992. *Treatment for Survivors of Childhood Sexual Abuse*. Puget Sound, Washington. *Mental Health/Social Services, Puget Sound Service Unit; Panel on Treatment Issues And Protecting Tomorrow's Leaders Conference*, 29 April.

This paper is an outline developed by conference organizers in response to childsexual abuse on reservations. The first part of the outline covers the Violation of Trust and the subcategories of exploitation, denial, secrets, conflict avoidance, appeasement, adult repression, and denial. The second part of the outline is titled "Sexual Abuse Teaches Children" and the subcategories of self-doubt, ignoring needs and rights, distrust, manipulation and coercion, kept secrets, and dissociation. The third part demarcates "Ways Victims React To Sexual Abuse" and the subcategories of self-blame, "damaged goods" syndrome, rebellion, ideal child, parent identification and pseudo-maturity, and physical complaints. The fourth part is entitled "As Abuse Survivors Mature" and the subcategories of repression which includes minimization, denial and dissociation, and substance abuse which includes lack of assertiveness, post-traumatic stress disorder, and sexual problems. The outline is comprehensive and incorporates various aspects of treatment measures as well as intervention and prevention measures.

INTERVENTION AND PREVENTION MANUALS

Adolescent Sexual Offender Treatment and Prevention Workshop. Indian Health Service Mental Health Program.

A paper on a workshop conducted by the IHS Mental Health Division to address the juvenile sexual offender. The purpose of the workshop is to outline the continuum of services needed for effective treatment of juvenile sexual offenders, and to develop a proposed community-based project for the evaluation and treatment of juvenile sexual offenders. This paper also focuses on the needs of the community and the ability for professional staff to meet those needs in respect to training and schooling.

The Battered Woman. The American College of Obstetricians and Gynecology-Technical Bulletin. An Educational Aid to Obstetricians-Gynecologists, Number 124, January 1989.

This bulletin identifies and defines the battered woman and the battered wife syndrome as well as the physical abuse. It also provides statistics on the frequency of the incidents and the public health impact. It presents evidence linking spousal abuse to child abuse. The purpose of this manual is to provide information for obstetricians and gynecologists, since they are the first primary care providers for many women, and the characteristics needed to identify physical abuse.

Breaking the Pattern: How Alberta Communities Can Help Assaulted Women and Their Families. Office for the Prevention of Family Violence. 1980. Excerpts from Handbook.

This handbook was developed for Alberta citizens to help assaulted women and their families. It outlines the problem by profiling the violent relationship, courtship, commitment, tension, first violent incident, how the pattern is set, and how the cycle can be broken.

When You Hit Too Hard. Gribber, Trish, Geddis, David, and Muir, Roy. 1979.

This is a parenting packet that teaches parents how to discipline children. It contains articles that query the parents about their methods of disciplining their children and has criteria that could help the parent in identifying potential situations that could lead to child abuse.

Wife Assault Intervention: Programs for Men. Prepared by the Ministries of Attorney General, Health, Social Services and Women's Equality in British Columbia.

These four packets were developed by the British Columbia Institute of Family Violence and are designed to help communities and tribes develop their own intervention program for men. The second packet is called "Review of the Literature" and it contains a historical essay on wife assault and a review of the legislative as well as the social views of this problem. Also included is a comprehensive list of relevant journals and reading materials. The third packet called "Guiding Principals for Services in British Columbia" focuses on developing guidelines for various agencies and/or tribes to design their own programs for assaultive men. The fourth packet is a "Program Development Handbook" which complements the guiding principles by providing practical assistance on what might work and what can be modified and adjusted to fit the needs of the community.

**SENATE SELECT COMMITTEE ON INDIAN AFFAIRS
TESTIMONY ON S. 2340
THE CHILD PROTECTIVE SERVICES AND FAMILY VIOLENCE PREVENTION
ACT**

Joseph Delfico. National Center on Child Abuse and Neglect, United States General Accounting Office, May 9, 1991.

Michigan Commission on Indian Affairs, Theodore Holappa, June 7, 1990.

Prevention of Child Abuse on Indian Reservations, American Psychological Association, Pamela Thurman, Ph.D., and Barbara Plested, June 7, 1990.

Inter-Tribal Council of Arizona, June 7, 1990.

Gila River Indian community, Thomas White, Governor, June 7, 1990.

Lorena Naseyowma, June 7, 1990.

Red Cliff Tribal Council, Red Cliff band of Lake Superior Chippewas, Richard Gurnoe, June 7, 1990.

Pueblo of Pojoaque, Jacob Viarrial, June 7, 1990.

The Navajo Nation, June 7, 1990.

Quinault Indian Nation, June 7, 1990.

American Academy of Pediatrics, Lance Chilton, M.D., Subcommittee on Indian Health, June 7, 1990.

Division of Clinical and Preventive Services, Department of Health and Human Services, Indian Health Service, Dr. Craig Vanderwagen, June 7, 1990.

JOURNAL ARTICLES, BOOKS

Bachman, Ronet. 1992. *Death and Violence on the Reservation: Homicide, Family Violence, and Suicide in American Indian Populations*.

This book looks at the causes of violence on the reservations by using personal interviews and linking them with the causes of racism. It mentions economics, prejudice and the realities of living on or near a reservation. The book is the most recent publication of violence on reservations. The most profound part of this book is the chapter titled "When Aggression is Turned Inward" which looks at the way in which Indians internalize the effects of racism and stereotyping. This is must book for people that want a good picture of violence on reservations.

Bell, C. C., Chance-Hill, G. 1988. Treatment of Violent Families. *Journal of the National Medical Association* 83:203-208.

This paper deals with family violence in African American communities, focusing primarily on homicide. Homicide intervention/prevention models are discussed. The author defines family violence as not being sporadic and irrational, but following reason or patterns; however, it is often impulsive.

Berlin, I. N. 1987. Suicide Among American Indian Adolescents: An Overview. *Suicide and Life Threatening Behavior* 17:219-232.

This paper presents an overview of the suicidal rates of tribes, describing different factors for each tribe, and some of the intervention and prevention measures that can be implemented. It also focuses on traditional and non-traditional roles within communities. In addition to traditional roles, models were established for suicidal prevention.

Billingham, R. E., Henningson, K. A. 1988. Courtship Violence. *Journal of School Health* 58:98-100.

This article focuses on the issue of courtship violence. Although more descriptive in identifying relationship violence, it does offer awareness for younger couples. A list of myths are presented and dispelled. As stated by the author these myths need to be dispelled because of the recent identification of courtship violence as a growing concern in need of further study.

The article also focuses on school health personnel from a high school and college perspective in regard to strategies for intervention, prevention, and identification. The intervention and prevention strategy is based on facilitating student awareness, support systems, promoting parental and community awareness and involvement, and cultivating and using an integrated curriculum.

Bowlby, J. 1984. Violence in the Family as a Disorder of the Attachment and Caregiving Systems. *The American Journal of Psychoanalysis* 44:9-25.

This paper focuses on the role of the psychoanalyst and psychotherapist in regard to family violence. The author mentions the inability of the early psychoanalyst to admit a causal factor of family violence in psychiatry. The attachment theory and the study's findings in the city of Los Angeles, California, in regard to separation anxiety in relationship abandonment issues and ultimately, family violence are discussed in great context.

Boyce, W. T., et. al. 1986. Social and Cultural Factors in Pregnancy Complications Among Navajo Women. *American Journal of Epidemiology* 124:242-253.

This paper focuses on the acculturation aspects of a traditional society in which the historical and current experiences of major socio-cultural change greatly effects the tribe as a whole. One of the aspects studied within the traditional "whole" family is pregnancy. Pregnancy was chosen as a variable of interest because of past work suggesting that both psychological and cultural factors may have relevant effects on the course of the pregnancy and the risk of obstetric or neonatal complications.

Check, W. A. 1985. 'Public Health Problem' of Violence Receives Epidemiologic Attention. *Journal of the American Medical Association* 254:881-891.

The issue of violence as a public health problem is addressed. The Violence Epidemiology Branch of the Centers for Disease Control is introduced and described as a formal organization that applies epidemiologic principles to the problem of violence. The article also discusses suicidal behavior as an aspect of violence.

Cole, P. M., Putnam, F. W. 1992. Effect of Incest on Self and Social Functioning: A Developmental Psychopathology Perspective. *Journal of Consulting and Clinical Psychology* 2:174-184.

This paper focuses on child sexual abuse and the effect it has in the development of the child. It proposes a model that would help individuals as well as the mental health providers focus on the short and long-term effects of child abuse. This will enable researchers to study the

association of incest, self and social development, as well as the psychiatric disorders reflective of early child abuse.

Collins, J. J., Schlenger, W. E. 1988. Acute and Chronic Effects of Alcohol Use and Violence. *Journal of Studies on Alcohol* 49:516-521.

A scholarly paper which addresses the etiological relationship between drinking and problem drinking to violence. Although the empirical association of drinking to violence is well established, it is generally accepted that alcohol use is not the sole factor directly influencing the cause of violence. This study used data from interviews conducted with 1,149 recently convicted male felons from North Carolina prisons. Consequently, the effects of alcohol use on violent behavior are classified as acute and chronic (DSM - diagnostic definition). The results from this study shows that the acute affects of alcohol were associated with incarceration for a violent act when demographic factors were controlled. It was found that chronic alcohol effects were not significantly associated with incarceration for a violent offense, however, measures of violence are indirect indications and should be used cautiously.

Cron, T. 1986. The Surgeon General's Workshop on Violence and Public Health: Review of the Recommendations. *Public Health Reports* 101:9-14.

This report gives a capsule overview of the 156 recommendations generated by the Surgeon General's Workshop on Violence and Public Health. A complete document is available from the Office of Surgeon General.

DeBruyan, L. M., et. al. 1988. Helping Communities Address Suicide and Violence: The Special Initiatives Team of the Indian Health Service. *American Indian and Alaska Native Mental Health Research* 1:56-65.

This paper outlines the philosophy which created the Special Initiatives Team (SIT) of the Indian Health Service (IHS) and explains the methods of operation with which SIT has been involved since its inception in 1987.

Dodge, K. A., Bates, J. E., Pettit, G. S. 1990. Mechanisms in the Cycle of Violence. *Science* 250:1678-1683.

The following paper discusses the incidence of child physical abuse in relation to development of aggressive behavior, and how this contributes to a cycle of violence. It was also found that children with histories of physical abuse had a greater rate of deviant behavior in the development of interpersonal relationships.

Dowd, Sisson, R. P., Kern, D. M. 1981. Socialization to Violence Among the Aged. *Journal of Gerontology* 36:350-361.

This paper focuses on approval of violent behavior among the young and elderly and their fear of victimization. An examination of family experiences as well as childhood experiences with violence was found to socialize the individual's attitude towards violence. A comparison of older

victims to younger victims is presented. It was assessed that younger victims disapprove less of violence than do non-victims, and older victims disapprove more of violence than non-victims.

Fischler, R. S. 1985. Child Abuse and Neglect in American Indian Communities. *Child Abuse and Neglect* 9:95-106.

This paper focuses on a wide variety of clinical identifications and stress factors that influence child abuse and neglect. This study also evaluates aspects that contribute to child abuse and neglect in Indian Communities. One of the major issues in non-Indian mental health professionals understanding maltreatment is the cultural barriers that exist. For example, the child rearing patterns of some Indian cultures can lead to mislabeling and misinterpretation by the non-Indian mental health professionals and this was found to be detrimental to the child's development.

Gelles, R. J. 1989. Child Abuse and Violence in Single-Parent Families: Parent Absence and Economic Deprivation. *American Journal of Orthopsychiatry* 59:492-501.

This paper tested the hypothesis that the risk of violence and abuse of children is greater in a single parent household than in a dual-caretaker household. A national survey was conducted of a sample of 6,000 households. The findings included studies that over-presented the single parent abuse hypothesis. The first study in 1970 reported that 29 percent of a sample of 1,380 validly reported cases were without a father or father substitute. A 1980 study reported that abused children were over-represented. One of the questions raised concerning previous findings is the absence of any detailed discussion of the higher rates of abuse and violence in single parent households. The results from this study were consistent with findings from previous studies and reports that abuse and violence rates were higher in single parent families.

Geoffrey, P. 1989. The Roots of Violence. *British Medical Journal* 297:1352-1353..

This article sheds light on the fact that family violence may not be on the increase but has just been overlooked or misdiagnosed in the past, and that it has always been in existence without the admission of society. Admission is the key to intervention and prevention.

George, W. H., Marlatt, G. A. 1986. The Effect of Alcohol and Anger on Interest in Violence, Erotica, and Deviance. *Journal of Abnormal Psychology* 95:150-158.

This paper describes the effects of alcohol expectancy, alcohol content, and anger provocation on the male interest to watching slides of different forms of erotica at levels ranging from neutral to violent-erotic.

Goodwin, J. 1985. Family Violence: Principles of Intervention and Prevention. *Hospital and Community Psychiatry* 36:1074-1079.

This article provides in-depth data about family violence. It provides a guide for professionals to prevent overlooking signs of family violence or misdiagnosing family violence. It provides insightful and helpful instruction for the intervention and prevention of family violence.

Harvey, M. 1988. A Regional Resource for Psychiatric Treatment of Victims of Violence. *Hospital and Community Psychiatry* 39:1192-1195.

This article discusses the Victims of Violence Program (VVP) at the Cambridge Hospital in Massachusetts. This program provides both social and educational services and has also become a regional resource for a new-style clinical treatment, consultation, and a training site. The VVP treats victimized women, indigent elderly, and chronic mentally ill victims of violence.

Honigfeld, L. S., Kaplan, D. W. 1987. Native American Postneonatal Mortality. *Pediatrics* 80:575-578.

This paper deals with American Indian infant mortality during the postneonatal period. Although the neonatal death among newborns are lower than the white race, postneonatal death rates are twice as high as the white race. One of the aspects this paper focuses on is the relationship between the socioeconomic conditions and the health care delivery systems.

Holtz, H. A., Hanes, C. 1987-1988. Education About Domestic Violence in U.S. and Canadian Medical Schools. *Journal of the American Medical Association* 261:972-973.

The New Jersey Medical School Domestic Violence Prevention Project surveyed 143 accredited U.S. and Canadian medical schools to determine their present Adult Domestic Violence (ADV) curriculum. It was found that 53 percent (of the 116 that responded) do not give any instruction about ADV to their students; 42 percent do receive instruction in at least one required course; and 6 percent do not receive any required instruction, however, have the option to choose the course as an elective.

Hughes, H. M. 1988. Psychological and Behavioral Correlates of Family Violence in Child Witnesses and Victims. *American Journal of Orthopsychiatry* 58:77-90.

This paper discusses study findings using a sample of children from similar economic backgrounds that were witnesses to parental violence. The children themselves had or had not been abused. Their levels of self-esteem, anxiety, depression, and behavior problems were examined. These studies were conducted in women's shelters and utilized the mother's perceptions and self reports. The findings indicated that there was an increase in problems relating to self-esteem, anxiety, depression, and behavioral problems in the abused witnesses as opposed to non-abused witnesses.

Kahn, M. W., et. al. 1988. An Indigenous Community Mental Health Service on the Tohono O'odham (Papago) Indian Reservation: Seventeen Years Later. *American Journal of Community Psychiatry* 16:369-379.

This article presents an example of a "fully indigenous tribally-operated mental health program" serving the Tohono O'odham Indian Reservation. It provides an overview of the progress, and areas of need, and explains the nuances such as tribal traditional medicines in dealing with a tribal community's problems in comparison with the rest of the non-indigenous population of the country. Self-help and self-determination are "keys" to prevention/intervention.

Kashani, J. H., et. al. 1992. Family Violence: Impact on Children. *Journal of American Academy of Child Adolescent Psychiatry* 31:181-189.

This article discusses four types of family violence (children, siblings, women, and elderly) and explores their development from biological and psychological perspectives. It discusses these issues as "serious societal" problems, discusses intervention strategies, and states that the key to prevention is examination of the family system.

Kirkland, K. 1982. Assessment and Treatment of Family Violence. *The Journal of Family Practice* 14:713-718.

This paper emphasizes the role of the family physician in detecting family violence. The physician is better able to gather knowledge and become intimate with the family, thus accumulating knowledge of patients and families. The physicians is in a position to detect the occurrence of abuse and neglect. This paper also focuses on the description and characteristics of family violence, the victims and the role they play within the family system, and batterers and the consequences impacting the family.

Lavoie, F. W., et. al. 1988. *Annals of Emergency Medicine* 17:143-149.

Violence in the emergency department is the topic of this paper. It addresses the issue of violent acts during the treatment response. The scenario involves verbal threats, physical restraints, and threats with weapons. The data is compiled from surveys of teaching institutions.

Lester, D. 1988. Rates of Personal Violence (Suicide and Homicide), Traffic Fatalities, and Alcohol Consumption. *Psychological Reports* 63:570.

A short article that reports the correlation of suicide and homicide rates. It was found that homicides rates were most often associated with traffic fatality rates while suicide rates were often associated with alcohol consumption.

Lester, D. 1989. Immigration and Rates of Personal Violence (Suicide and Homicide). *Psychological Reports* 65:1298.

This article addresses the issue of immigration and the rates of suicide and homicide. Findings indicated that immigration rates were not significantly correlated with homicide or suicide rates. The study involved 18 industrialized nations.

Lester, D. 1989. Association of Population Growth, Technological Development and Social Integration on Rates of Personal Violence (Suicide and Homicide). *Psychological Reports* 64:462.

This report debates that homicide and suicide are associated in opposing areas by contrasting and comparing different ideas of population growth and technological advancement to the division of labor and social integration.

Lujan, C., et. al. 1989. Profile of Abused and Neglected American Indian Children in the Southwest. *Child Abuse and Neglect* 13:449-461.

This article focuses on child abuse in a southwestern state. It utilizes a study sample of 53 children targeted by the local IHS Hospital. Data used were from three sources: Child Protection Team (CPT) files, IHS medical records, and community health nurses and representatives, mental health technicians and staff, and social workers. The results of this study show that child neglect was more prevalent, however, the majority of the children were both abused and neglected.

Manson, S. M., Walker, R. D., Kivlahan, D. R. 1987. Psychiatric Assessment and Treatment of American Indians and Alaska Natives. *Hospital and Community Psychiatry* 38:165-173.

This paper discusses the cultural aspects of American Indian and Alaska Natives (AI/AN) in the psychiatric treatment of AI/ANs. Findings indicate that group therapy is more often chosen as a form of treatment for American Indians. The paper also discusses the role of traditional healing methods in treatment. The traditional methods of treatment are: the four circles, a visualizing technique, the talking circle, a form of group therapy using sweetgrass, sage or cedar, and the sweat lodge.

McLeer, S. V., Anwar, R. A. H. 1987. The Role of the Emergency Physician in the Prevention of Domestic Violence. *Annals of Emergency Medicine* 16:1155-1161.

This article addresses the role of the emergency department in the treatment of battered women. The article presents a theory that on many occasions the battered women is treated medically and surgically and often released. However, there is no intervention for the victim or efforts to prevent future abuse. A seven-step protocol and model for staffing is presented which provides for evaluative services and intervention in cases of domestic violence.

Miller, B. A., et. al. 1989. Spousal Violence Among Alcoholic Women as Compared to a Random Household Sample of Women. *Journal of Studies on Alcohol* 50:533-540.

This article reports that alcoholic women were found to suffer greater incidents of spouse abuse, both moderate and severe, as well as negative verbal interactions.

Munns, D. C. 1985. Validation of the Defining Characteristics of the Nursing Diagnosis. "Potential for Violence." *Nursing Clinic of North America* 20:711-722.

The primary objective of this study is to review the documented patient records and the characteristics that define the nursing diagnosis "potential for violence." The etiological characteristics of the "potential for violence" diagnosis are supported by the literature in varying degrees. Adult male patients with a history of being violent or having the potential for violent behavior were selected as a case study.

Parker, B., Ulrich, Y. 1990. A Protocol of Safety: Research on Abuse of Women. *Nursing Research (Commentary)* 39:248-250.

This commentary offered by the Nursing Research Consortium on Violence and Abuse presents information concerning the importance of safety for the abused women in a research setting. Due to an increase in research projects on this topic, a standard safety protocol for new researchers or Institutional Review Boards was implemented. The NRCVA offers guidelines and states the overall goal is to insure "an ethical approach to the safety and autonomy of participants and the researcher."

Pelton, C. L. 1982. Intervention in Family Violence: A Role for the Physician and for Society. *Family Violence* 72:163-170.

This article dispels the belief that a person's home is sacrosanct. In cases of family violence, the author states that intervention is the key; intervention by family physicians is the best because they have a greater capability to get to the heart of the matter, and to society as a whole. This article provides recommendations for physicians in recognizing signs and symptoms of family violence. It also states that family violence is a widespread problem for society as a whole, a position suggested by studies. In that respect, it dispels some of the fallacies that has society spellbound. such as psychosis is a usual factor in family violence, human violence and aggression are instinctive behaviors, and abusive persons are in tight control of themselves.

Petersen, L. P., et. al. 1984. Pregnancy Complications in Sioux Women. *Journal of Obstetrics and Gynecology* 64:519-523.

This paper focuses on the health status of Sioux Indians residing on reservations in South Dakota. It documents evidence of a high incidence of socio-economic health related disorders and pregnancy related complications. The University of South Dakota Department of Obstetrics and Gynecology collaborated with the Aberdeen Area IHS to identify and assess risks and provide patient management for pregnant Sioux women.

Piasecki, J.M., et. al. 1989. Abuse and Neglect of American Indian Children: Findings From a Survey of Federal Providers. *American Indian and Alaska Native Mental Health Research* 3:43-62.

This paper presents findings developed from a survey that was conducted from September 1984 to February, 1986. This survey addressed the growing concern of child abuse and neglect in Indian communities. It also demarcated the mental health of needs of Indian children and adolescents. This information was used as a basis for funding programs, and the design of more appropriate and effective services.

The respondents were asked to identify children who, in the providers opinion, were in need of mental health treatment. Providers were asked to include all children known to have been abused or neglected. The sample was compromised of 1,155 children representing 50 tribes. The results in this sample were 67 percent Indian children who were described by providers as neglected or abused (including sexual abuse).

Randall, T. 1990. Domestic Violence Intervention Calls for More Than Treating Injuries. *Medical News Perspectives, Journal of the American Medical Association* 264:939-940.

This article contains information about the intervention and identification by physicians who treat women in the the emergency room for physical injuries related to abuse. Statistics are presented to document the lack of support and treatment offered by physicians.

Raymond, C. 1989. Campaign Alerts Physicians to Identify and Assist Victims of Domestic Violence. *Medical News and Perspectives, Journal of the American Medical Association* 261:963-964.

This is a report on the campaign to increase the awareness of wife beating. It focuses on the primary care givers of women (obstetricians and gynecologists) in improving their awareness on domestic violence. It references a bulletin available to 27,000 members of the American College of Obstetricians and Gynecologists (ACOG). This bulletin provides information on identifying physically and mentally the victims of wife beating by physicians.

Red Horse, J.G. 1980. Family Structure and Value Orientation in American Indians. Social Casework. *The Journal of Contemporary Social Work* 462-467.

This article contains information relevant to human service professionals in contact with American Indian communities about the "structural fabric characteristics of American Indian extended family systems." In order to assure delivery of quality services to American Indian communities, the author guides the discussion with three critical perspectives: identifying and articulating family circumstances, analyzing family value orientations and purposeful behavior, and assessing the implications for the professions.

Rhoades, E.R., et. al. 1988. The Indian Health Service Approach to Alcoholism Among American Indians and Alaska Natives. *Public Health Reports* 103:621-627.

This report outlines the IHS approach to the prevention of alcoholism among American Indians and Alaskan Natives. The IHS's strategic plan for alcoholism control works collaboratively with the Secretary's Initiative and the Anti-Drug Act. The report indicates that tribal actions have a critical role on these efforts.

Rosenbaum, A., O'Leary, D. 1981 Marital Violence: Characteristics of Abusive Couples. *Journal of Consulting and Clinical Psychology* 49:63-71.

This paper presents a comparative study based on a sample of abusive couples to non-abusive couples and dysfunctional nonviolent couples at a center for domestic violence. A questionnaire was distributed to a sample of abused wives and abusive husbands utilizing the center. The most significant results indicated that when comparing abusive husbands and non-abusive husbands, the "abusive husbands were less assertive with their wives, they had a history of child abuse, and had experienced parental spousal abuse in their families".

Rosenbaum, J.L. 1989. Family Dysfunction and Female Delinquency. *Crime and Delinquency* 35:31-44.

This article examines the family backgrounds of a group of women committed to the California Youth Authority as adolescents in the '60's, and their delinquent behavior in adulthood. Findings indicate that these women came from dysfunctional families, and they tended to follow in their mother's footsteps (e.g. bearing children at an early age, choices of men resembling mothers' choices). It also found that these women were double victims e.g., victims of the criminal justice system as well as victims of their own environment. This article provides important data and findings for determining the association of family dysfunction and female delinquency, and criminality in adulthood.

Sadoff, R. L. 1986. Sexual Violence. *Bulletin of the New York Academy of Sciences* 62:466-476.

This paper was presented as part of a symposium on homicide: The Public Health Perspective. It addresses the act of violent behavior through sexual means. The author differentiates various aspects of sexual violence creating categorical subdivisions regarding sexual offenders. These include myths that have abounded regarding sexual offenders, the diagnosis and recognition of sexually violent individuals, considerations of prevention of sexual violence, and finally, treatment of sexually violent individuals.

Sargent, M. 1987. Studies of Victims of Violence. *Hospital and Community Psychiatry* 38:1143-1144.

This report contains data collected on sexual assault in the Los Angeles, California; and Durham, North Carolina areas and its effect on the victim's mental health. In North Carolina, the majority of women respondents were white and the others black. In California, the majority of respondents were non-Hispanic white and Hispanic. The findings indicate that sexual assault victims had higher rates of mental disorders and psychiatric symptoms. In addition, sexually assaulted victims used mental health services more often than those not sexually assaulted.

Saunders, D.G. 1992. A Typology of Men Who Batter: Three Types Derived from Cluster Analysis. *American Journal of Orthopsychiatry* 62:264-275.

This paper includes technical data and analyses including variables and factors of the typology of men who batter. The author identifies three types of men who batter. Through a cluster analysis the types are: 1) family only aggressors, 2) generally violent aggressors, and 3) emotionally volatile aggressors.

Schafer, J.R., McIlwaine, B.D. 1992. Investigating Child Sexual Abuse in the American Indian Community. *American Indian Quarterly*, Spring, 157-167.

This article written by two Federal Bureau of Investigation (FBI) agents with experience in investigating crimes on American Indian reservations, discusses problems in investigating child sexual abuse in American Indian communities. The article presents several cases where the investigator and informant have had to stop their interview because of inexperience and lack of knowledge of Indian communities and culture. It advises that the key to a successful investigation is understanding and familiarity with the local customs and traditions.

Schwartz, I. 1989. Alcohol and Family Violence. *The Journal of the American Medical Association* 262:351-352.

This letter identifies alcohol abuse as a major contributor to a host of medical and social problems, including family violence.

Straus, M.A. 1986. Domestic Violence and Homicide Antecedents. *Bulletin of the New York Academy of Medicine* 62:446-465.

This paper focuses on three aspects of family violence presented in three sections within the journal. The first section describes the nature and extent of homicides between family members. The second section describes the extent of non-lethal violence within the family and its connection to homicide. The third section views intra-family violence from a public health perspective.

Taliaferro, E. 1988. Violence in the Emergency Department: A Very Real Concern. *Annals of Emergency Medicine* 17:166.

This editorial discusses the concerns about violence in an active emergency department (ED). These concerns are defined and documented through the findings of a survey conducted on institutions with ED that have 40,000 or more patients. It was concluded that ED violence is, in fact, a significant problem in the participating hospitals. It was also found that there is inadequate administrative response, and that there is a critical need to develop a preventive risk management approach.

Viken, R. M. 1992. Family Violence: Aids to Recognition. *Post Graduate Medicine* 71:115-122.

This article focuses on methods to assist the family physicians in recognizing characteristics of family violence. It provides an example of a case in which recognition of family violence went unnoticed by a family physician, and provides explanations on why this happens.

Lenore E. Walker. 1979. *The Battered Woman*.

Lenore E. Walker's groundbreaking work identifies the problem of domestic violence through the eyes of the victim. She offers insight by using personal accounts and her own research techniques. Even though her viewpoint is from a feminist perspective, she hopes that the perspective will anger society to action. One of the most significant part of this book is the chapter where she talks about the cycle theory of violence and how it applies to women and violence. The three phases she outlines is the tension building phase, the explosion or acute battering incident, and the calm loving respite.

Widom, C. S. 1989. Child Abuse, Neglect, and Adult Behavior: Research Design and Findings on Criminality, Violence, and Child Abuse. *American Journal Orthopsychiatry* 59:355-387.

This article presents a prospective cohorts design to see if the association of early exposure to family violence and abuse leads to criminality as an adult. There is some uncertainty and debate

on the validity of this assumption, and the extent of child abuse and neglect. Although the association between child and adult behavior is a generally accepted mindset of health professionals and workers, this theory has not passed any scientific/empirical scrutiny. The purpose of this study is to incorporate improvements of design, operationalism, and conceptualism.

The results have demonstrated that early childhood victimization is associated with adult criminal behavior. Twenty-nine percent of those who were victimized as children were arrested for criminal offenses as adults. Twenty-one percent of the control group used in this survey were arrested for criminal offenses comparatively.

Widom, C.S. 1989. The Cycle of Violence. *Science* 244:160-166

This article examines and focuses on findings in cohort studies conducted in previous journals. Earlier studies have shown that being abused or neglected as a child increases one's risk of criminal behavior as adults. However, the majority of the abused and neglected children do not have violent criminal behavior as adults. In a 2-year study, the relationship between child abuse and neglect are examined. Information on new research techniques are also provided.

Wolfe, D.A., et. al. 1988. Children of Battered Women: The Relation of Child Behavior to Family Violence and Maternal Stress. *Journal of Consulting and Clinical Psychology* 53:657-665.

This paper focuses on children of violent and non-violent backgrounds and their likelihood of showing short-term or long-term adjustment difficulties. Mothers were interviewed and rated their children's behavior on the Achenbach Child Behavior Checklist and completed measures of family violence (Conflict Tactics Scale) and maternal stress (Life Experiences Survey and General Health Questionnaire).

The results of this study demonstrate a significant prevalence of behavior problems and diminished social competence. Twenty-six percent of the children were reported to have problems and of this number, males showed more signs of adjustment difficulties than females. The results of the data collected suggest an indirect and significant impact on children exposed to family violence.

Wyatt, G.E., Guthrie, D., Notgrass, C.M. 1992. Differential Effects of Women's Child Sexual Abuse and Subsequent Sexual Revictimization. *Journal of Consulting and Clinical Psychology* 60:167-173.

This study examines the differential effects of sexual revictimization in a community sample of 248 African-American and White American women age 18 to 36. Previous literature defined revictimization through a variety of methodologies; this study examines several definitions. Two methods are used in defining sexual revictimization: 1) incidents of sexual abuse involving contact and non-contact (e.g., unwanted observations of people exhibiting themselves publicly and engaging in masturbatory behavior) in women before and after age 18 and 2) the total number of incidents reported by women.

Those respondents who reported contact abuse before the age 18 (44 percent) experienced either contact or non-contact abuse in adulthood, and 30 percent reported only contact abuse incidents since age 18. This paper also states that women who were sexually abused during childhood were 2.4 times more likely to be abused as adults.

Zylke, J.W. 1988. Violence Increasingly Being Viewed as Problem of Public Health; Prevention Programs Attempted. *Journal of the American Medical Association* 260.

This commentary discusses the increase in violence and its commonplace in our society, and the attempt to intervene by "community involvement and treatment of aggression" in the Boston area. The Violence Prevention Project is discussed utilizing the actions of intervention by community involvement and treatment of aggression. Assessments of this project do not indicate a favorable decrease in violence because it precludes evaluation of the Violence Prevention Project's program evaluations.

READERS

Child Abuse/Neglect and Mental Health Problems. Article in the Washington Post

The Washington Post offers a short synopsis of an article that entails results of a study generated by the University of Colorado. This article concludes that if Indian children today were to have a reduction in abuse and neglect, their health risks would be reduced. Incidence of abuse and neglect in future generations would also be positively affected. It also presented statistics indicating that two-third of Indian children receiving mental health treatment are abused and/or neglected.

Detecting Elder Abuse: A guide for physicians. Geriatrics: Trauma and Prevention Series. The Washington Post.

A scholarly paper written on the problem of abuse and neglect of elderly people. This paper focuses on the relatively new area of elder abuse and the actions that doctors take to identify and assess the elderly patient if abuse is suspected. Outline of elder abuse detection and indicators is presented..

Family Violence Bulletin. Family Violence Research and Treatment Program, University of Texas at Tyler. Vol. 7, No. 2, Summer, 1991.

This bulletin contains announcements and articles addressing book and media reviews and research and treatment issues on family violence.

Fetal Alcohol Syndrome Among Native Americans. Alcohol Health and Research World, National Institute on Alcohol Abuse and Alcoholism, United States Department of Health and Human Services. Vol. 7, No. 2, Winter, 1982/83.

This article discusses a pilot project developed by the IHS to study and deal with the problems of FAS on Indian reservations in the Southwest. The project consisted of the following components: training and education, clinical diagnosis and treatment, and research and prevention. The project was piloted from 1980 through 1982.

Inside a Sioux Reservation: Villages of Despair. Rosebud Indian Reservation, South Dakota. Washington Post.

Part one of a series of articles focused on social injustice, medical injustice, and legal injustice within the Rosebud Indian Reservation. This article specifically addresses issues concerned with the breakdown of "basic civil liberties and essential institutions."

Multicultural Approaches to Child Abuse: Problems, Issues and Organizational Strategies, Collaborated paper by Harry G. Gin, Milciades Morales, Betty Newbreast and Jorge Santis

This paper examines the problems related to participation in child abuse and neglect programs by minorities. It states the need for these programs to be culturally relevant. It strongly conveys that unless these issues are reconceptualized, challenged and developed, the outcome of minorities will be that of second class citizens with unequal access to these programs.

ATTACHMENT 6

DATA COLLECTION GUIDE

DATA COLLECTION GUIDE

NATIVE AMERICAN FAMILY SYSTEMS AND COMMUNITY STRENGTHS: ASSESSMENT OF PATTERNS OF VIOLENCE

Name: _____		
Title: _____		
Organization: _____		
Address: _____		
City: _____	State: _____	Zip Code: _____
Reservation/Tribe(s) Served: _____		
Phone No.: (____) _____	Date: ____ / ____ / ____	

This document is not a survey instrument and, therefore, is not subject to the OMB review clearance process. This guide is to assist in discussion of the issues and in conducting the on-site case study.

The goal of this study is to obtain general impressions about violence in this community, and recommendations of ways to deal with the problem of family violence including abuse of children, spouses, elders, and other relatives. All information obtained in this study will remain anonymous and will be kept confidential.

1. How would you rate the problem of **violence, in general**, on this reservation? *(Please circle one number.)*

Big Problem 1 2 3 4 5 No Problem

2. How would you rate the problem of **family violence** in this reservation? *(Please circle one number.)*

Big Problem 1 2 3 4 5 No Problem

3. Please rate the scope of each of these specific types of violence on this reservation. (*Please circle one number for each category.*)

Homicide						
Big Problem	1	2	3	4	5	No Problem
Physical Assault without Weapon						
Big Problem	1	2	3	4	5	No Problem
Assault with weapon (e.g., gun, knife, etc.)						
Big Problem	1	2	3	4	5	No Problem
Suicide						
Big Problem	1	2	3	4	5	No Problem
Rape						
Big Problem	1	2	3	4	5	No Problem
Gangs						
Big Problem	1	2	3	4	5	No Problem

4. Please rate the scope of each of these specific types of **family violence** on this reservation. (*Please circle one number for each category.*)

Wife Abuse (Battering)						
Big Problem	1	2	3	4	5	No Problem
Husband Abuse (Battering)						
Big Problem	1	2	3	4	5	No Problem
Child Abuse (Battering)						
Big Problem	1	2	3	4	5	No Problem
Elder Abuse (Battering)						
Big Problem	1	2	3	4	5	No Problem
Child Sexual Abuse (Rape/Incest)						
Big Problem	1	2	3	4	5	No Problem

5. How frequently is alcohol a factor in family violence? *(Please circle one number.)*

Almost Always	1	2	3	4	5	Never
------------------	---	---	---	---	---	-------

6. Efforts to prevent family violence on this reservation are generally *(Circle one number for each option):*

6a. Needed	1	2	3	4	5	Not needed
------------	---	---	---	---	---	------------

6b. Successful	1	2	3	4	5	Unsuccessful
----------------	---	---	---	---	---	--------------

7. To what degree are people on the reservation aware of the problem of family violence? *(Please circle one number.)*

Most are Aware	1	2	3	4	5	Most are Unaware
-------------------	---	---	---	---	---	---------------------

8. How concerned is the community about family violence? *(Please circle one number.)*

Very Concerned	1	2	3	4	5	No Concern
-------------------	---	---	---	---	---	---------------

9. Resources for victims of family violence on this reservation are *(Please circle one number).*

Excellent	1	2	3	4	5	Non Existent
-----------	---	---	---	---	---	--------------

10. To what degree do people on your reservation have access to available resources? *(Please circle one number).*

Easy Access	1	2	3	4	5	No Access
-------------	---	---	---	---	---	-----------

10a. What is being done for prevention of family violence on your reservation?

10b. What more do you think should be done and by whom? _____

11. Please check those agencies/organizations that offer sources of information and those that actually provide services regarding family violence in this community (*Check all that apply*).

Agency/Organization/Resource	Sources of Information	Provide Services
Social Workers		
Community Health Representatives (CHRs)		
Public Health Nurse/Community Health Nurse		
IHS Clinic/Hospital		
Tribal Programs or initiatives		
State Programs or initiatives		
County Programs or initiatives		
Tribal Courts		
Law Enforcement		
Child Welfare Workers		
Churches		
Schools		
Federal programs		
Other, Please specify		

12. Does your agency/organization provide educational materials regarding family violence? (*Please check one response.*)

☐ Yes ☐ No

12a. If no, why not? _____

13. What are your job-related practices concerning family violence? (*Check all that apply.*)

- ☐ Treatment/service provided with little or no involvement with family
- ☐ Open discussion of possible role of abuse/violence in situation
- ☐ Referrals to community-based resources (shelters, social service, psychiatrist, etc.)
- ☐ Use tracking system for victims of family violence
- ☐ Participate in multi-disciplinary teams dealing with family violence

14. Have you had to deal with the problem of family violence in your job? *(Please check one response.)*

☐ Yes

☐ No

If no, skip to question 16.

14b. If yes, please describe. _____

15. How often have you encountered this/these problem(s)? *(Please check the response that best applies.)*

Very
Rarely

1

2

3

4

5

Frequently

16. How long have you worked in your current position? *(Please check the response that best applies.)*

☐ less than 1 year

☐ 1-2 years

☐ 3-5 years

☐ 5-10 years

☐ 10-15 years

☐ over 15 years

17. Has your organization developed a policy or set of procedures for dealing with family violence? *(Please check one response.)*

☐ Yes

☐ No

☐ Don't know

17a. If yes, please describe. _____

- 17b. If yes, did/do you follow your organization's policy or set of procedures? *(Please check one response.)*

☐ Yes

☐ No

17c. If no, why not? _____

17d. Does the policy or procedure(s) call for you or your organization to conduct follow-up on the case? *(Please check one response.)*

☐ Yes

☐ No

17e. If yes, please describe these follow-up procedures. _____

17f. If yes, do the procedures involve a tracking system?

☐ Yes

☐ No

18. Have you ever referred a case, or person, to an organization or group equipped to deal with family violence? *(Please check one response.)*

☐ Yes

☐ No

If no, go to question 19.

18a. If yes, how many such referrals have you made? _____

18b. How well have these referrals worked out? *(Please circle one number.)*

Good
outcome

1

2

3

4

5

Poor
outcome

19. Do local law enforcement officers in your community handle domestic disputes involving violence or the threat of violence (e.g., hitting a spouse, threatening family members with a gun or knife)? *(Please check one response.)*

☐ Yes

☐ No

19a. If yes, please describe how these situations are handled. _____

20. Are there any shelters in your community where victims of violence can go? *(Please check one response.)*

☐ Yes

☐ No

☐ Don't Know

If No, or Don't know, skip to Question 23.

20a. If yes, how many? _

27. How much formal training have you had regarding working with victims of family violence?
(Please circle one number.)

Extensive 1 2 3 4 5 None

27a. Please describe your training. _____

28. Have you participated in any workshops or seminars on family violence? (Please check one response.)

☐ Yes ☐ No

28a. If yes, please specify. _____

29. Do you have any advice or suggestions for this study so that we can better understand the problem of family violence on this reservation? _____

30. Do you have any recommendations for the intervention/prevention of family violence? _____

31. Do you have any concluding comments — is there anything else you would like to add?

ATTACHMENT 7

TYPES OF SECONDARY DATA

Tribal	<p>Population statistics (e.g., age, sex, marital status)</p> <p>Organizational chart</p> <p>Labor force statistics</p> <p>Geographic data (e.g., reservation maps, surrounding counties, etc.)</p> <p>Transportation systems (levels of accessibility, isolation factors, etc.)</p> <p>Employment opportunities</p> <p>Education</p> <p>Income (ranges)</p> <p>Resources</p>
Judicial Data	<p>Ordinances, regulations, bylaws governing reservation regarding violence (all types)</p> <p>Tribal court system</p> <p>Other judicial systems used (e.g., state, county, federal, etc.)</p> <p>Homicide rates</p> <p>Suicide rates</p> <p>Assault rates</p> <p>Sex crime rates (e.g., rape, assaults/deadly weapons, assaults/without deadly weapons, child abuse)</p> <p>Child abuse</p> <p>Spouse abuse</p> <p>Elder abuse</p>
Medical Data	<p>General health statistics (e.g., user population, facilities available, services available, etc.)</p> <p>Diagnoses of violence</p> <p>Diagnoses related to suspicion of abuse</p> <p>Sexual assaults, battery</p> <p>CHR CHRIS II data</p> <p>Referral statistics</p>
Social Service Data	<p>General information (e.g., tribal, state, county, federal resources available, services provided, etc.)</p> <p>Child abuse reports</p> <p>Child sexual abuse</p> <p>Child neglect</p> <p>Suspected/reported cases of child sexual abuse</p> <p>Referrals</p>
School/Educational Data	<p>Statistics (age groups served, dropout rates, etc.)</p> <p>Suspected/reported cases of child abuse</p> <p>Suspected/reported cases of child neglect</p> <p>Suspected/reported cases of child sexual abuse</p> <p>Referrals</p>
Law Enforcement Data	<p>Statistics on homicide, assault, abuse, etc.</p>
Other Data	<p>Previous relevant studies conducted by/for the tribe</p> <p>Resolutions, reports, documents prepared by tribe related to family violence</p> <p>Reports/studies and evaluation conducted by IHS, BIA, of general area</p>

